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Interactions between neurotic symptoms and interpersonal dynamics throughout psychodynamic psychotherapy: Four empirical case studies

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"*Freud's idea: in madness the lock is not destroyed, only altered; the old key can no longer unlock it, but it could be opened up by a differently constructed key*" (Wittgenstein, diary remark from 1938)

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PREFACE

The present doctoral dissertation starts from the notion – central to classical and contemporary psychodynamic theory, diagnostics, treatment and research (e.g., Blatt, 1974, 2004, 2008; Luborsky, 1984; Vanheule, 2014; Verhaeghe, 2004) – that neurotic symptoms are inherently embedded in subjects' broader interpersonal functioning; and specifically focuses on dynamic interactions between evolutions in patients' symptomatic and interpersonal functioning throughout the course of supportive-expressive psychodynamic treatment (Luborsky, 1984).

The dissertation comprises a *General Introduction (Chapter 1)*, four empirical case studies (*Chapters 2 – 5)*, and a *General Discussion and Conclusions* chapter including a multiple case study *(Chapter 6)*, appended by the *Dutch-language Summary (Nederlandstalige Samenvatting)*.

In the ***General Introduction (Chapter 1)***, the theoretical and empirical background of the present research project is illuminated. We document how, in an attempt to meaningfully structure and reduce the apparent wide variety of symptomatic expressions within the field of neurotic psychopathology – and specifically counterpoising the expanding number of isolated DSM- and ICD-diagnoses – the symptom specificity hypothesis (SSH; Blatt, 1974, pp. 155-157) intended to identify and describe specific associations between distinctive types of neurotic symptoms and distinctive modes of interpersonal functioning. We illustrate that the SSH is based on the broader psychodynamic theory (Blatt, 1974, 2004, 2008) that subjective functioning is essentially mobilized by two central psychological dimensions. In this respect, the anaclitic/dependent dimension is theorized to be associated with interpersonal tendencies towards closeness, and so-called hysterical symptoms; while the introjective/self-critical/autonomous dimension would be mainly focused on self-definition and separation from others, and generally related to so-called obsessional symptoms.

Previous research into symptom specificity, however, has yielded markedly inconsistent findings. In the present project, we argue how this inconsistency might be due to several conceptual and methodological issues related to the cross-sectional group designs of previous studies. We advance how we, in response, deliberately install an alternative research design that provides a closer methodological match to Blatt's primary intentions (i.e., to delineate distinctive dynamic symptom-interpersonal evolutions throughout subjects' life courses, in general, and treatment processes, in particular). Additionally, we show how this project's research design explicitly addresses a number of recommendations from earlier studies on symptom specificity as well as broader claims in psychotherapy research. Furthermore, it attends to the marked absence of empirical case research on the SSH to date (see Willemsen et al., 2015).

We further substantiate how, in doing so, the project attempts to meaningfully enrich existing research foundations on the SSH in a way that is both closer to complex theoretical underpinnings as

to clinical dynamics, and advance intended contributions to theory-development through proposed conceptual extensions and/or modifications (i.e., hypothesis-refinement; Stiles, 2009, 2015).

For this purpose, symptom specificity is successively tested in the present project through ***four empirical case studies (Chapters 2 – 5)*** on neurotic patients who were treated in a real-world clinical practice by means of supportive-expressive psychodynamic therapy (SET; Luborsky, 1984). Two patients were selected with prototypical obsessional symptoms (Chapters 2 – 3), and two patients with prototypical hysterical symptoms (Chapters 4 – 5).

In each empirical case study, the ***research aim*** was two-fold:

1. To test concrete operationalizations of the SSH;
   In order to specifically delineate what constitutes a test for the SSH.
   I.e., the hypothesis-driven part of each study.
2. Additionally (beyond the scope of previous research into the SSH): to thoroughly investigate the dynamic unfolding of associations between patient's symptomatic and interpersonal functioning throughout the studied treatment process, with specific attention to therapist interventions and extra-therapeutic events that impacted on this ongoing process;
   In order to enable detection of novel features that were not initially captured by the starting-point hypotheses and that may lead to theory development through proposed extensions or modifications.
   I.e., the exploratory (Hill, 1990) or discovery-oriented (Mahrer, 1988) part of each study.

In order to optimize the possibility of capturing intended complexities, and to illuminate distinct aspects of (the broad spectrum of possible changes in) the variables under study (e.g., Hill, Chui, & Baumann, 2013), each empirical case study relies on a rich dataset, assembled via multiple sources of quantitative and qualitative materials, gathered from multiple perspectives, and collected longitudinally at regular intervals from (pre-)treatment until multiple follow-up measurements.

To provide conformity between the SET (Luborsky, 1984) treatments under study, and the consequent data-analyses, Core Conflictual Relationship Theme (CCRT; Luborksy & Crits-Christoph, 1998) methodology is applied to examine patients' narratives concerning interpersonal functioning.

As an overarching data-analytic approach, Consensual Qualitative Research for Case Studies (CQR-c; Jackson, Chui and Hill, 2011) is used, which has specifically been developed to assess clinically complex material in a rich and nuanced fashion. In this data-analytic process, triangulation (e.g., Hill, 2012; Yin, 1994) is established between different data sources, between competing perspectives, and through critical intercommunion between a guiding operational set of theoretical statements and a constant return to the raw data.

As such, the research project starts in ***Chapter 2*** with a first empirical case study of a patient with obsessional symptoms. Based on the substantiated observations that patient's symptoms were rooted in profound ambivalences between autonomous and dependent interpersonal functioning within

significant relationships (i.e., instead of the predicted monopoly of separating relational behavior; thus suggesting more complex interpersonal dynamics than originally assumed by the classical SSH), in the second case study on obsessional pathology ***(Chapter 3)***, concrete SSH operationalizations were contrasted to alternative hypotheses based on these observed complexities in Chapter 2. Both cases document higher complexity than postulated by the SSH and advance proposed refinements.

Next, ***Chapter 4*** comprises the first empirical case study on hysterical pathology. As – in contrast to the cases on obsessional symptoms – this case study reports confirming evidence for all SSH predictions, the second case study in ***Chapter 5*** starts anew from the same SSH operationalizations (i.e., without alternative hypotheses), and further examines dynamic symptom-interpersonal associations throughout therapy.

Finally, in line with recommendations to augment the contribution of individual case studies by systematic cross-case comparisons (e.g.,Iwakabe, 2011; Iwakabe & Gazzola, 2009), a ***multiple case study*** is presented in the ***General Discussion and Conclusions (Chapter 6)***. Quantitative and qualitative findings from the hypotheses-driven and discovery-oriented parts of the four case studies are systematically juxtaposed and compared – both within, between and across the two pairs of similarly diagnosed patients – to identify and articulate similarities, repeated observations and common themes, as well as significant differences, pertaining to manifest constructs and underlying dynamics (Iwakabe & Gazzola, 2009; Yin, 1994). We indicate how these findings relate to the starting-point hypotheses, and what our case analyses have additionally produced with respect to the project's discovery-oriented and theory-building aims. Pertaining to notions of transferability (Hanson, Creswell, Clark, Petska, & Creswell, 2005) and analytical generalization (Yin, 1994), conclusions are further discussed in light of current theoretical and clinical knowledge and practice. Finally, we address the strengths and limitations of the research project, and suggest valuable directions for future investigation into symptom specificity.

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1

GENERAL INTRODUCTION

THEORETICAL AND EMPIRICAL BACKGROUND

In the first chapter of this doctoral dissertation, we enlighten the theoretical and empirical background of the present research project. Starting from issues related to present-day prevailing diagnostics of neurotic symptomatology, we move to a discussion of psychodynamic notions on the inherent interpersonal embedment of symptoms, and specifically finger Freud's and Blatt's contributions in this respect. We outline Blatt's psychodynamic theory on symptom specificity, and subsequently zoom in on the symptom specificity hypothesis (Blatt, 1974, pp.155-157) as the pivotal starting-point hypothesis for the present project. Considering inconsistent findings on this hypothesis in previous cross-sectional group studies, we advance the project's research design, substantiate the overall research aims and concrete predictions, document the research material, and conclude by addressing the applied methodological and data-analytic steps.

Neurotic Symptomatology

Ever since the beginning of psychology as a discipline, attempts were made to meaningfully distinguish normal (i.e., non-symptomatic) functioning from psychopathology, and to further structure psychopathology into different types, categories or dimensions. The internationally most widely used classification systems to diagnose psychopathology are the Diagnostic and Statistical Manuals (DSM) of the American Psychiatric Association and the International Classification of Diseases and Related Health Problems (ICD) of the World Health Organization. Both classification schemes have facilitated international communication among diagnosticians worldwide. However, over the past few decades, dissatisfaction has risen amongst a growing number of clinicians and researchers with the merely phenomenological, symptom-centred nature of these manuals (e.g., Blatt, 2008; Cierpka et al., 2007; Hill, 2012; Vanheule, 2014; Verhaeghe, 2004). Shortcomings of mere descriptive approaches have numerously been documented by previous authors, who question the manuals' diagnostic reliability and validity, point to the large amount of various, isolated diagnostic categories, the related omnipresence of comorbidity in diagnoses, and according limited clinical applicability (e.g., Blatt, 2008; Desmet, 2007; Gotlib & Hammen, 2002; Maleval, 2002; for a comprehensive argumentation, see Vanheule, 2014). Psychodynamic therapists, who consider psychopathological symptoms to be inherently embedded within patients' broader subjective functioning, therefore see little practical relevance in purely symptom-based diagnoses (e.g., Vanheule, 2014; Verhaeghe, 2004). It has previously been argued that the daunting multiplicity in the phenomenological field of symptoms can be reduced in a meaningful and clinically applicable manner by clarifying the underlying structures that relate symptoms to each other (e.g., Cierpka et al., 2007; Desmet, 2007; Vanheule, 2014; Verhaeghe, 2004).

In this respect, contemporary psychodynamic diagnostics (e.g., Vanheule, 2014; Verhaeghe, 2004) departs from a Freudian-Lacanian orientation in which three main categories are diagnostically distinguished, as principally underlying the diversified field of psychopathology, i.e., neurosis, psychosis and perversion. In the present doctoral dissertation, we particularly focus on *neurotic* symptomatology.

The Interpersonal Embedment of Symptoms

Within the neurotic realm, Freud (1978 [1915c]) situated the "cause" of psychopathology at the level of the libidinal organization, which, in his view, determined both character formation, the accompanying interpersonal characteristics and the specific manifestations of clinical symptoms (Freud, 1978 [1908b]). Throughout various writings Freud distinguished between *hysterical neurosis* – as principally fuelled by the oral drive, which interpersonally aims at fusion with significant others – from *obsessional neurosis* – as mainly driven by the anal drive, aimed at isolation and separation from

others (e.g., Verhaeghe, 2004. Though both (drive-laden) interpersonal dimensions are present in neurotic subjects, one of the two habitually predominates over the other and marks the relational behavior of the subject in question. In his clinical work, Freud numerously illustrated that, dependent on which dimension prevails, other types of neurotic symptoms appear at the phenomenological level. In general terms, the typically hysterical interpersonal dimension would primarily be associated with symptoms manifesting at the somatic level (e.g., conversion). The obsessional interpersonal dimension, on the other hand, would principally be characterized by symptoms manifesting at the cognitive or mental level (e.g., obsessive-compulsive complaints; see also Desmet, 2007). On this point, we stress that we are aware that Freudian theory on the connections between these different elements was more complex, detailed and clinically elaborated than the concrete statements cited above (which, e.g., exclusively link interpersonal patterns with one partial drive). Yet, operationalizing psychodynamic theory into statements that lend themselves for empirical investigation (see below) unavoidably entails a reduction.

Blatt's Theory on Symptom Specificity

As a result of Freud's consistent return to the interpersonal domain when analyzing neurotic symptoms, underlying determining dynamics of symptoms were principally described in interpersonal terms (e.g., Desmet, 2007). Accordingly, an important focus of post-Freudian psychodynamic research has been on the identification and description of dysfunctional *interpersonal styles*, and their associations with *symptomatology*. In this respect, Blatt (1974, 2004, 2008) put forward a theory on *anaclitic* and *introjective* dimensions in psychopathology, which is generally considered to be the Anglo-Saxon equivalent of Freud's theory on hysterical and obsessional neurosis, and which has attracted a great deal of research attention to date.

Concretely, Blatt described *normal* (i.e., non-pathological) subjective functioning to be mobilized by two central psychological dimensions, i.e., relatedness and self-definition, which habitually develop in a reciprocally balanced, dialectic process throughout the life span; though most subjects place more emphasis on one tendency over the other. *Interpersonal relatedness* generally refers to the need to establish and maintain meaningful interpersonal relationships with significant others, centered on closeness, stability, trust, care and protection. *Self-definition* pertains to longings to constructively define the self as an entity separate and differentiated from others, with a sense of autonomy, control, and achievement, and valuing feelings of self-worth and integrity (Blatt, 1974, 2004, 2008).

Psychopathology results from disruptions in this dialectal process, due to exaggerated, one-sided emphasis on one of the two dimensions, at the expense of the other.
Preoccupation with issues of relatedness gives rise to symptoms pertaining to the *anaclitic* (also termed *dependent*) configuration (which is equivalent to *hysterical* psychopathology as described by

Freud). Dependent subjects are described to possess particularly strong needs to be loved, cared for and protected, and to be particularly vulnerable to feelings of abandonment and loss of love. Direct conflict is anxiously avoided or minimized by overly conforming to others. Preoccupation with interpersonal relatedness stretches to neglect of a constructive development of the self, which is primarily defined in terms of the quality of interpersonal experiences (i.e., subjects intensely rely on others to provide and maintain a sense of well-being).

On the other hand, excessive concern with self-definition generates symptoms within the *introjective* (also termed *self-critical* or *autonomous*) domain (equivalent to Freudian *obsessional* pathology). Autonomous individuals disproportionately focus on personal achievement, self-esteem, individuality and control. Though they intensely attempt to achieve a sense of separation and independence from others (who are generally experienced as controlling and intrusive), their interpersonal relations tend to be highly ambivalent, out of the (underlying dependent) fear of losing others' love. Autonomous patients often find themselves unable to resolve and integrate contradictory feelings towards significant others (Blatt, 1974). As they particularly urge to be acknowledged, respected and admired, these subjects chronically fear to be disapproved of and criticized (Blatt, 1974, 2004, 2008).

Within each configuration, various expressions of psychopathology are not seen as separate, isolated diseases (as holds for DSM and ICD classifications), but as *interrelated*. Framed within a *dimensional* view of different levels of psychological organization, various manifestations within each configuration are considered to range on a continuum from more primitive/undifferentiated to more mature/integrated. They share basic similarities in characteristic interpersonal tendencies, in the nature of predominant conflicts, and in vulnerabilities to specific life events. Hence, Blatt's differentiation between two broad types of symptoms (i.e., as structurally embedded within one of the two configurations) is not based on the severity or intensity of the manifest symptoms, but on the *nature* of the *experiences* that seem important to the patients concerned.

The anaclitic – introjective division is consistent with a wide range of theories from attachment and interpersonal orientations, and its diagnostic validity is supported by considerable research evidence (for a review, see Blatt & Luyten, 2009). Importantly, the classification of neurotic symptoms within these fundamental configurations also proves of *clinical importance*, as dependent and autonomous patients tend to respond differently to the therapeutic process, i.e., they express their therapeutic gains in different ways, as they change in dimensions most salient to their basic personality organization (for a review, see Blatt, 2008). Thus, in addition to providing a coherent model to deal with the frequent problematic issue of comorbidity in categorical diagnostic systems, Blatt's diagnostic system also yields important implications for psychotherapeutic interventions and pathways for potential progression within each configuration. In other words, in addition to treatment focus on the more overt symptomatic expressions, intense concerns about issues of impaired interpersonal relatedness or of a disrupted sense of self-worth need to be a *central therapeutic topic* (Blatt, 2008).

Interestingly, in this respect, Blatt explicitly advances Supportive-Expressive Therapy (SET; Luborsky, 1984), which varies slightly from classic psychoanalytic treatment in its higher focus on the interpersonal or relational domain. SET is therefore discussed more detailedly below in the section on the present project's research material.

The Symptom Specificity Hypothesis

Within each configuration, patients presenting with pathological problems are claimed to structurally share some fundamental characteristics. The *symptom specificity hypothesis* (Blatt, 1974, pp.155-157) is a formal expression of the specific associations between *symptoms* and *interpersonal functioning*. In line with Freud (see above), Blatt stated that

- The anaclitic/dependent interpersonal style – marked by non-assertive, overly accommodating and self-sacrificing behavior aiming at establishing relational closeness (Blatt, 2004, pp.180-183) – is specifically related to depressive symptoms (centered on feelings of interpersonal loss and abandonment), phobias, anxiety, and somatic symptoms (i.e., typically hysterical symptoms; Verhaeghe, 2004);
- The introjective/self-critical/autonomous interpersonal profile – characterized by vindictive and cold behavior in order to procure separation and autonomy towards others (Blatt, 2004, pp.180-183) – is distinctively associated with depressive symptoms (centered on feelings of worthlessness and failure of personal achievement), obsessive-compulsive symptoms and symptoms centered around aggressive urges (i.e., typically obsessional symptoms; Verhaeghe, 2004).

Towards Empirical Investigation of the Symptom Specificity Hypothesis

Inconsistency in Previous Research on Symptom Specificity

In order for a theory to be (and continue to be) *scientifically beneficial*, *clinically useful* and *coherent* (i.e., provide a "general, precise, and realistic" account of the phenomena under study; Stiles, 2009, p.10), it is crucial that empirical research provides quality control on theory, i.e., by comparing the theoretical statements with grounded observations. Stiles (2009, 2015) advances 'theory building' as a vital part of scientific progress. Research endeavours should aim at assessing and improving existing theories to build an evidence base that strengthens our confidence that the theory is empirically grounded and clinically applicable.

Over the past decades, Blatt's (1974, pp. 155-157) symptom specificity hypothesis has been put to the test in several *cross-sectional group studies*. Markedly, however, these studies have yielded

inconsistent findings[1] (see also Burke & Haslam, 2001; Desmet, 2007). Some studies supported symptom specificity (e.g., Desmet, Vanheule, Groenvynck, Verhaeghe, & Bogaerts, 2007; Luyten et al., 2007; Robins, Hayes, Block, Kramer, & Villena, 1995; Robins & Luten, 1991;), others reported partial support (e.g., Abela, McIntyre-Smith, & Dechef, 2003; Allen, Ames, Layton, Bennetts, & Kingston, 1997; Burke & Haslam, 2001; Desmet, Vanheule, & Verhaeghe, 2006; Persons, Burns, Perloff, & Miranda, 1993; Persons, Miranda, & Perloff, 1991; Robins, Bagby, Rector, Lynch, & Kennedy, 1997; Robins, Block, & Peselow, 1989), while still other studies found no evidence at all for symptom specificity (Desmet et al., 2008; Jolly, Dyck, Kramer, & Wherry, 1996; Klein, Harding, Taylor, & Dickstein, 1988).

Conceptual and Methodological Considerations Related to Previous Research

We advocate that the lack of converging results might be due to conceptual and methodological issues related to the cross-sectional group designs of cited studies.

On a *conceptual* level, in order to test theoretical statements in statistical hypothesis-testing designs, often complex psychoanalytic theories are necessarily reduced to less complex statements, which are at risk of being less accurate (e.g., Desmet, 2013a) and which fail to address the sensitivity to context present in clinical theories (Stiles, 2009). In the symptom specificity hypothesis, for example, interpersonal characteristics associated with obsessional symptoms are reduced to a tendency towards separation and autonomy. However, both classical psychodynamic theories such as those of Freud and Lacan, and contemporary theories such as Blatt's (2004, 2008) describe a more complex interpersonal dynamic in which emphasis is put on the issue of *ambivalence* in obsessional neurosis. These authors all stress that underneath the inclination towards separation (Thanatos drive), the opposite tendency towards fusion (Eros drive) is also at work (e.g., Verhaeghe, 2004). The resulting ambivalence, the incessant alternation between hate and love, separation and fusion, is supposed to form the underlying structure present in all obsessional symptom formations. Thus, one of the reasons why the results of the above-mentioned studies did not converge might be the reductionist nature of the concrete hypotheses that were tested in fore-mentioned studies. In other words, the classical symptom specificity hypothesis (which was tested in cited studies) potentially yields an underestimation of the clinical complexity of associations between symptoms and interpersonal dynamics (as addressed in the more complex theories on which it is based). Hence, potentially failing to provide a coherent theoretical account of specific associations, the classical hypothesis may need to be *refined* on some points (Stiles, 2009).

For that purpose, however (i.e., on a *methodological* level) research designs are needed that enable to systematically include a greater extent of complexity, and allow for the detection of

[1] I.e., inconsistency was observed both in clinical and in non-clinical samples, between participants within the same study, and between different studies.

(potentially crucial) extra factors not initially captured by predefined operationalizations (as further addressed below). It has numerously been raised that nomothetic[2] research designs, though valuable in many ways, lack this particular suitability (e.g., Stiles, 2009; Hill, 2012).

Importantly, Blatt's theory (1974, 2004) is a *clinical* theory, pertaining to valid, clinically applicable diagnostics within the broad field of (overtly miscellaneous) neurotic symptoms. It primarily intended to define *dynamically unfolding interplays* between symptoms and interpersonal characteristics *over time*, and, more specifically, throughout the course of a *therapeutic process*. Sound psychodiagnostics proves to be a cornerstone in tailoring subsequent treatment avenues and according clinical interventions (e.g., Vanheule, 2014; Verhaeghe, 2004).

This means that pertinent investigation into these dynamics optimally requires a longitudinal, clinical data set. Markedly, however, symptom specificity has thus far always been tested in nomothetic research using cross-sectional group designs. More specifically, all cited studies:

1. Defined *average*, *invariant tendencies* in (large) groups of participants, resulting in rule-based, abstract knowledge. Yet, disregarding intra-individual variability and (potentially relevant) contextual factors as confounds or "error", generalized knowledge is not able to capture the multiple and dynamic factors operating in clinical, real-world practice (e.g., Vanheule, 2014). Considering, however, that psychological processes obey person-specific dynamic laws (Molenaar, 2004), inter-individual variability in average tendencies fails to explain a substantial part of the variation in psychological phenomena in which researchers and practitioners are interested (e.g., Caldwell, Cervone, & Rubin, 2008);
2. Were *cross-sectional* in nature, i.e., relying on measurements of symptomatic and interpersonal features at one single time point, consequently describing static associations and obscuring the anatomy of change (e.g., Vanheule, 2009);
3. Solely relied on *quantitative, patient-reported measurement* of participants' symptomatic and interpersonal functioning.

Yet, validity of self-report symptom measures has previously been argued to be limited, since they are subject to a variety of biases (e.g., Desmet, 2007; Schwarz, 1999). Moreover, since psychodynamic theory (e.g., Freud, Blatt, Lacan) explicitly states that subjects' symptoms are largely sculptured out of individually warded off psychic material, it reasonably follows that (a) symptoms are partly excluded from conscious awareness and, consequently, from direct accessibility through selfreport, (b) the sole use of predefined items on standardized measures (i.e., on which participants are asked to respond to conceptualizations the questionnaire designer has constructed; Hill, Chui, &

[2] Nomothetic literally means "proposition of the law". In psychological research, nomothetic measurement generally refers to measures that are observed on a relatively large sample of participants, and result in findings on (sub)group patterns, average or typical tendencies, and often decontextualized and generalized knowledge. In this respect, nomothetic research is commonly contrasted to idiosyncratic research, which is carried out on the level of a (small number of) single case(s), and typically includes more contextualized detail.

Baumann, 2013; McLeod, 2001) are insufficient to cover the whole picture. Standardized measures may not accurately reflect the patient's subjective ill-being, inner experiences and central problem areas (McLeod, 2001), which, however, ought to be vital diagnostic focal points (e.g., Vanheule, 2014; see also General Discussion of this doctoral dissertation). Although numbers are convenient in allowing reseachers to conduct statistical analyses and compare to norm groups, we do not know how subjects *interpret* the questionnaire items to which they assign a certain number. Moreover, when assessed regularly throughout treatment, patients may start to understand and respond to the items differently, although they might feel the same (e.g., McGrath & Johnson, 2003; McLeod, 2011). In addition, Shedler, Mayman and Manis (1993) show how a "healthy score" can represent both healthy (i.e., non-clinical) functioning and a facade of mental health created by psychological defenses.

Need For In-depth Empirical Case Research into Symptom Specificity

While nomothetic research has inarguably proven to be a valuable methodological approach in accounting for patterns and common features amongst the complexity of human psychic functioning, and will continue to yield scientific profit (Barlow & Nock, 2009), a unilateral focus on this type of research provides a *delimited picture* of the complicated phenomena under study, and strongly *confines further enrichment of the existing research foundations*, as it leaves obscured an array of (potentially meaningful) aspects that can further shed light on the observed inconsistent findings.

Therefore, we argue there is an urgent need to *complement* nomothetic research into symptom specificity with alternative research designs that present a *closer methodological match* to the current research object, i.e., the distinctive, clinical associations between types of neurotic symptoms and modes of interpersonal functioning, and their distinctive evolutions (i.e., regressions and/or progressions) throughout subjects' life course (in general) and treatment (in particular). In fact, good social science has been described (Flyvbjerg, 2006) to be primarily problem driven – and not methodology driven – "in the sense that it employs those methods that, for a given problematic, best help answer the research questions at hand" (p.242). Since not one single methodological perspective is able to capture all the complexity, researchers' "tendency to apply the same methodologies, operationalizations, and/or samples entails a marked restriction in the ability to investigate complex relations that exist in the real world" (McGrath & Johnson, 2003, p.39).

Therefore, we argue that, prior to *additional statistical testing* of the (reduced) symptom specificity hypothesis in nomothetic research, further research into symptom specificity should firstly target at alternative research designs. More specifically, based on the inconsistent findings of previous research, and the documented conceptual and methodological issues pertaining to that specific type of research, we argue (as further documented below, and in line with recommendations of earlier research on symptom specificity, e.g., Desmet, 2007; Huprich, Rosen, & Kiss, 2013; Pilkonis, 1988) there is a pressing need for:

1. Empirical case-based research into symptom specificity;
2. Applied to a longitudinal psychotherapeutic process;
3. Using an extensive, multiple source, multiple perspective data set that allows thorough inquiry of clinical complexity of theorized associations beyond mere quantitative, patient-reported assessment. More specifically, data should allow to:
    a. Systematically test concrete operationalizations of the symptom specificity hypothesis (i.e., to delineate what constitutes a test for the hypothesis); and
    b. Further explore and discover novel features that are potentially relevant but not readily captured by (predefined) confirmatory hypotheses. As such, areas can be detected in which the classical symptom specificity hypothesis is in potential need for refinement (Stiles, 2009).

Yet, evidence-based case studies are markedly underrepresented in symptom specificity research. In fact, consultation of www.singlearchive.com – a recently established electronic database of case studies published in ISI-ranked journals (and currently including 446 case studies on psychodynamic treatment; Willemsen et al., 2015) – yielded no empirical cases on symptom specificity.

Before discussing how we address cited need in the current research project, we firstly document each of the three raised – and related – arguments below.

Empirical Case Research.

First, empirical case research specifically allows for *'theory building' and 'hypothesis refinement'* (Stiles, 2009), as it covers important aspects that might be overlooked in nomothetic designs (Iwakabe & Gazzola, 2009). Stiles (2003) explicated how case study research not only serves to confirm or disconfirm existing theories, but more importantly, to extend, modify or elaborate on a theory.

For one thing, it has been advocated that the very meaning of psychopathology depends on the *context* in which it occurs (e.g., Hill, 2012; Vanheule, 2014). Contextual influences, however, are typically disregarded as confounds in nomothetic research; yet, are explicitly incorporated by empirical case research. By integrating (intra- and extra-therapeutic) contextual elements into so-called '*thick descriptions'* (Pontoretto & Grieger, 2007) of naturally unfolding processes over time, systematic case studies are able to *suggest complexities*, and potentially generate *new insights* into the psychological phenomena under study. In that way, they provide a distinctive, unique way of contributing to scientific development in a clinically useful manner (Edwards, Dattilio, & Bromley, 2004). McLeod (2013) marks case studies' attention to *processes* as particularly advantageous in enabling to identify factors that are intrinsic to outcome (i.a., the observed interpersonal and/or symptomatic transformations during therapy), but which are not readily accessed through group-level measurement tools. The ability to explore *interactions* amongst different processes or factors, and to thoroughly describe and analyze

how these processes and events unfold *over time*, is further advocated to constructively enrich existing research foundations (McLeod, 2013). Accordingly, the case study's typical proximity to the *complexity* of *naturally-occurring phenoma* (i.e., in constrast to constraining multifaceted variables under carefully controlled conditions) and its multiple wealth of details has recurrently proven to be gainful for the development of a *nuanced* view of the phenomena under study (e.g., McLeod, 2013; Stiles, 2009; Vanheule, 2014).

Consequently, case-based research most importantly complements nomothetic research by testing the limits of generalizability of group-based findings. Group studies – habitually high in internal validity and breadth, but low in external or context validity and depth (Flyvbjerg, 2006) – need to be extended by case studies – generally rich in depth, but inherently poor in breadth – in order to guarantee a sound development of social science. Case research assesses the *transferability* and *clinical applicability* of group-based findings (which are often observed under researcher-controlled conditions) to individual patients met in every-day clinical practice, i.e., in the idiographic, naturalistic contexts in which multiple factors dynamically operate in ongoing processes (McLeod, 2013). As such, case studies constitute a *critical test* for *established theories* (sometimes referred to as 'falsification', see Flyvbjerg, 2006).

Hence, based on the limited practicality of group-based, context independent knowledge *as such* (as the group comparisons that are routinely used in psychotherapy outcome research obscure the variability in outcomes and processes of individual patient-therapist dyads; Iwakabe, 2011; Strupp, 1980a), increasingly more authors agree on the *additional* necessity of studying intra-individual variation in ongoing psychological processes at the level of individual subjects (e.g., Barlow & Nock, 2009; Caldwell, Cervone, & Rubin, 2008; Desmet, 2013; Iwakabe & Gazzola, 2009; Molenaar, 2004; Stiles, 2009; Vanheule, 2014).

Yet, single case research has long been looked upon with a certain contempt by the academic world, especially during the heydays of the nomothetic paradigm (+/- from 1940 until 2000), as traditional case studies or clinical vignettes often lacked methodological rigor or transparency, and frequently solely relied on therapists' informal process notes or reflective memories. While many of these case studies have, notwithstanding, mobilized crucial insights into complex human functioning, and while many contemporary well-established theories still bear essential roots in them, it deems paramount (i.e., in order to continue theories to be dynamized by new discoveries) that further case research establishes the *methodological rigor* required to make a *strong argument* in *scientific debate* (see also Hill, 2012; Iwakabe, 2011; Yin, 2014). Over the past decade, increasingly prosperous endeavours in that direction have prompted a rising number of scholars to agree on the rightful methodological status that systematic, empirical case research deserves (e.g., Gomm, Hammersley, & Foster, 2000; Yin, 1994).[3] [4]

[3] This is e.g., illustrated in the fact that a rising number of prominent professional journals in social science and psychotherapy increasingly grants space to the publication of (systematic/evidence-

Longitudinal Psychotherapeutic Processes.

Second, in line with both Blatt's (1974, 2004) ambitions and with recommendations of previous research (e.g., Huprich, Rosen, & Kiss, 2013; Pilkonis, 1988) there is an urgent need for research that addresses symptom specificity in the context of a *psychotherapeutic process in action*, where the *longitudinal*, dynamic interplays between symptoms and interpersonal characteristics can be studied as they naturalistically manifest and evolve throughout treatment. The close examination of the unfolding of events across time is viewed as one of the most pragmatic and practice-oriented forms of psychotherapy research (e.g., Fishman, 2005).

Following our first argument for empirical case research, we additionally state that, in group designs, (psychotherapeutic) processes are often considered to be linear in nature, though a number of studies have demonstrated that this assumption is not entirely justified (e.g., Hill, 2012, p.39; Luyten, Blatt & Mayes, 2012). On the contrary, it has been argued that important changes at the level of symptomatology and interpersonal relationships can best be understood as non-linear functions (e.g. McGrath & Johnson, 2003; Luyten, Blatt & Mayes, 2012; Stiles & Shapiro, 1989). Hence, as systematic case studies enable researchers to observe and analyze complicated psychological phenomena, and have the additional advantage of avoiding specific types of measurement error frequently occurring in group designs (see also Desmet, 2013b), they are key to understanding the complexity of (non-linear patterns of) therapeutic change.

Multiple Source, Multiple Method Data Sets.

Thirdly, in line with Blatt's (1974, 2004) ambitions to foster an in-depth understanding of how neurotic symptoms and interpersonal dynamics are distinctively associated with each other, and how and why distinctive evolutions (i.e., progressions and regressions along the two defined dimensions) take place over time, it is foremost important to *broadly map* the *multifaceted variables* under study. Research endeavors should therefore aim at assembling a rich data set that enhances the likelihood of capturing different aspects of (the wide spectrum of possible changes in) both variables (e.g., Hill, Chui, & Baumann, 2013). As has previously been argued (e.g., Johnson & Onwuegbuzie, 2004; Hill, 2012), data from self-report questionnaires (especially completed at a single time point) only cover one

based/pragmatic) case studies. For example: recently, a Special Series has been established in the APA-credited journal Psychotherapy for the exclusive publication of 'Evidence-Based Case Studies' that meet the guidelines set forward by current editor Mark Hilsenroth, based on the American Psychological Association's criteria for Evidence-Based Practice (APA, 2006) and the 'Clinical Utility' dimension in the Criteria for Evaluating Treatment Guidelines (APA, 2002). These guidelines correspond to our third argument, to which the current research project complies.

[4] Iwakabe (a prominent contemporary author on case research methodology in clinical psychology) importantly points to the predominance of the case study as a research tool in Japan (e.g., with respect to publications in professional journals and attendance at professional conferences in the field of clinical psychology and psychotherapy), which has derived from researchers' joint efforts to give clinical practice a central role in psychotherapy research. Aiming to "achieve the goal of generating a systematic and coherent clinical body of knowledge" (Iwakabe, 2011, p.340), case research has been given a primary role over other types of research that do not directly draw data from direct contact between patients and therapists.

(small) portion of this spectrum, which has prompted authors from previous research on symptom specificity to recommend future inclusion of alternative assessment tools.

Acknowledging that different (quantitative and qualitative) measures, administered from different perspectives (e.g., patient, therapist, researcher), each illuminate unique aspects of the studied variables, Hill, Chui and Baumann (2013) advocate a *multimethod, multiperspective approach* to studying process and outcome. As such, findings from one approach can shed light on the meaning of findings from another (Dattilio, Edwards, & Fishman, 2010), and a way is installed to transgress the limited epistemological potentials and biases introduced by the isolated use of individual measures. While drawing on the strengths of each approach, possible one-sized distortions or omissions are modulated or corrected through synthesis of different findings, resulting in a more balanced view of what has been discovered, and a more differentiated extrapolation of the findings' implications (McGrath & Johnson, 2003).

Overall Research Aims of the Present Project

In the present doctoral project, we specifically address the documented need in the current research climate on symptom specificity (as unravelled above in three related arguments). Before presenting the specific research questions, and defining the research material and data-analytic approach, we explicate the project's overall aims.

Starting from inconsistent findings in previous nomothetic research on Blatt's (1974, pp. 155-157) symptom specificity hypothesis, for which we raised conceptual and methodological considerations, the present project aims to respond (1) to recommendations of earlier studies on symptom specificity to make use of *longitudinal* designs (e.g., Desmet, 2007; Pilkonis, 1988) in *clinical* settings (e.g., Desmet, 2007; Huprich, Rosen, & Kiss, 2013; Werbart & Forsström, 2014) with a *variety of measures* (e.g., Desmet, 2007); (2) to broader claims in psychotherapy research to direct research endeavors towards the increased use of *idiographic* studies, specifically accounting for intra-individual variability in the multifaceted psychological phenomena under study (e.g., Barlow & Nock, 2009; Dattilio, Edwards & Fishman, 2010; Hill, 2012; Iwakabe & Gazzola, 2009; McLeod, 2013; Stiles, 2009; Vanheule, 2014); and (3) to the marked absence of empirical case studies on symptom specificity to date (Willemsen et al., 2015).

As such, the present project intends to provide a *closer methodological match* to Blatt's primary intentions to define distinctive, clinical associations between two broad types of neurotic symptoms and modes of interpersonal functioning, and delineate their distinctive, dynamic evolutions (i.e., progressions and/or regressions) throughout subjects' life courses (in general) and treatment processes (in particular).

In doing so, the project attempts to *enrich existing research foundations* on Blatt's symptom specificity hypothesis in a way that is both *closer to complex theoretical underpinnings* as to *clinical dynamics* (see also Yin, 1994).

For this purpose, symptom specificity is successively tested in *four empirical case studies* (Chapters 2 – 5) on neurotic patients who were treated in a real-world clinical practice by means of psychodynamic therapy (i.e., Blatt's theoretical and therapeutic orientation). More specifically, two patients were selected with prototypical obsessional/introjective symptoms (Chapters 2 – 3), and two patients with prototypical hysterical/anaclitic symptoms (Chapters 4 – 5; details on case selection and diagnosis are presented in discussion of the data set below).

In each empirical case study, the research aim was two-fold:

1. To test concrete operationalizations of the classical symptom specificity hypothesis (as presented in detail below; in accordance with previous research into symptom specificity)[5];

   In order to specifically delineate what constitutes a test for the classical hypothesis.

   I.e., the hypothesis-driven part of the study.

2. Additionally (beyond the scope of cited previous research):

   To thoroughly investigate the dynamic unfolding of associations between patient's symptomatic and interpersonal functioning throughout the therapeutic process, including therapist interventions and extra-therapeutic events impacting on this ongoing process;

   In order to enable detection of novel features that were not readily captured by the starting-point hypotheses, and that may lead to theory development through proposed extensions or modifications.

   I.e., the exploratory (Hill, 1990) or discovery-oriented (Mahrer, 1988) part of the study.

Meaningful unexpected findings grant the opportunity to constructively suggest possible complexities in areas where the classical symptom specificity hypothesis potentially needs to grow. For starting-point theoretical statements gradually become more differentiated as vital theoretical concepts become more precisely defined or new concepts are added (McLeod 2013; Yin, 2014). We thus explicitly incorporated this additional exploratory part of the study to allow for potentially beneficial contribution to theory building through hypothesis-refinement (Stiles, 2009, 2015).

As such, the present project's findings may possibly add to further clarification of previously reported inconsistent observations on symptom specificity.

[5] As our research design (i.e., longitudinal single case design) differs from previous studies (i.e., cross-sectional group design), and as the present project intends to assess symptomatic and interpersonal functioning more richly than has previously been done (i.e., beyond mere quantitative, patient-reported assessment), it follows that the presented concrete operationalizations are no exact duplicates of those tested in above-mentioned previous research (e.g., predictions pertaining to specific qualitative elements [see section on research questions and expectations below] were not included in previous studies).

The project starts (Chapter 2) with a first empirical case study on a patient with obsessional symptoms, in which the hypothesis-driven part of the study comprises predictions based on the classical symptom specificity hypothesis (as outlined above). Next, in case unpredicted findings or significant complexities are observed that were not initially captured by the classical hypothesis, the second case study of a different patient with obsessional symptoms (Chapter 3) will contrast the same predictions, based on Blatt's classical hypothesis, with alternative predictions, based on the findings from Chapter 2. The same line of reasoning is followed for the empirical case studies of two patients with hysterical symptoms (Chapters 4 – 5).

Subsequently, in the General Discussion of this doctoral dissertation, findings from the hypothesis-driven and discovery-oriented parts of the four case studies are compared, integrated and synthesized (i.e., "case comparison"; Iwakabe & Gazzola, 2009) in the form of a multiple case study (Yin, 1994). Iwakabe (2011) argued that careful contrast and comparison of a small number of similar case studies[6], and examining the transferability of findings by elucidating common and particular core processes (Fishman, 2005), significantly augments the contribution of single case studies.

Case Selection and Overview of the Research Material

Broader Database of Single Cases

In contrast to previous studies on symptom specificity, which all relied on cross-sectionally gathered data from (large) groups of participants, in which symptomatic and interpersonal well-being were both assessed via one sole, predefined, patient-reported measure, in the current project, we deliberately chose to select data out of a longitudinally assembled database of (audio-recorded and verbatim transcribed) psychodynamically oriented treatments, containing data on patients' symptomatic and interpersonal dynamics from multiple sources and multiple perspectives (described in detail below)[7].

[6] For the present doctoral project, this is: four patients treated in the same clinical practice by the same therapist, using the same treatment manual (Supportive-Expressive Therapy, SET; Luborsky, 1984; further discussed in the section on 'Research Material'), made up by two pairs of patients, with similarly diagnosed symptoms within each pair.

[7] The database has been constructed in 2009 at the Department of Psychoanalysis and Clinical Consulting of Ghent University as part of a research project (centered on studying the processes and outcomes of psychodynamic therapies with neurotic patients) that constituted the main groundwork for the following large-scale Randomized Controlled Trial (RCT) study (which has been started in 2015 at the same Department and is currently operational). This RCT study is listed on the online 'Open Science Framework' as the 'Ghent Psychotherapy Study' (GPS), and entitled 'Differential Efficacy of Supportive-Expressive and Cognitive-Behavioral Interventions in Dependent and Self-critical Depressive Patients: A Randomized Trial' (for full details, see https://osf.io/mf2d7/).
At the start of the present doctoral project, the database comprised of twenty audio-recorded open-ended (i.e., without a predetermined restriction in number of sessions) supportive-expressive therapies. All patients presented neurotic symptomatology, and were diagnosed and treated by the same therapist in a private clinical practice without any interference of a research team (i.e., 'naturalistic' therapies). All patients provided written informed consent to participate in the study and to

Treatments were conducted according to the manual of Supportive-Expressive Therapy (SET) of Luborsky (1984), which is:

- generally acknowlegded to assemble the most representative and commonly used techniques in psychodynamic therapy (which makes our project appealing to a large number of psychodynamic therapists);
- based on a theory (Luborsky, 1962) that is in marked consonance with Blatt's (1974, 2004) statements concerning specific treatment pathways and according mechanisms of change for dependent and autonomous pathology (which makes these treatments well suited for study of Blatt's symptom specificity hypothesis).

SET therapies have previously been used in studies on dependency and autonomy (for a recent study, see e.g., Chui, Zilcha-Mano, Dinger, Barrett, & Barber, 2016). Its efficacy has been demonstrated for a variety of psychological disorders (Leichsenring & Leibing, 2007).

In line with Blatt (1974, 2004), Luborsky's (1962) fundamental theory states that patients' symptoms are essentially rooted in (i.e., they originate from and are maintained by) maladaptive relationship patterns, which are all underpinned by a typical '*core conflict'*, characteristic for each patient. A patient's core conflict is theorized to comprise of (1) his/her interpersonal wishes, (2) his/her typical experiences of others' responses (that frustrate and/or gratify these wishes), and in response, (3) his/her own typical feelings and reactions. In SET, therapists and patients mutually engage in progressively conceptualizing and targeting these core conflicts through a constructive and flexible alternation between 'supportive techniques' (mainly directed at building and maintaining a strong working alliance) and 'expressive techniques' (mainly aimed at "working through" conflicts).

More specifically, Luborsky (1962, 1984) theorized that psychotherapeutic endeavours aiming at *transforming* a patient's *core conflict* will bring about *interpersonal transformations*, and *subsequent symptomatic alterations*; which has previously been evidenced by e.g., Grenyer and Luborsky (1996), Luborsky and Crits-Christoph (1998), and Slonim, Shefler, Gvirsman, and Tishby (2011). In this way, SET may trigger specific mechanisms of change pertaining to personality aspects that relate to interpersonal functioning, such as dependency or autonomy.

Case Selection

The present doctoral project constitutes the first profound research endeavor that makes use of these data. To address the research aims described above, we selected *four neurotic patients* out of the larger pool of twenty, based on the following criteria.

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publish the individual case materials. In the present doctoral dissertation, all possibly identifying information has been changed to protect confidentiality. The global research procedure and informed consent form have been approved by the Ghent University ethical committee.

1. We selected:
    a. Two patients with DSM-IV-TR diagnoses (APA, 2000) that are – according to Freud's and Blatt's diagnostic distinctions – prototypically categorized as *obsessional symptoms* (i.e., without clear co-morbid hysterical/anaclitic symptoms). As further discussed in Chapters 2 – 3, patients met DSM-IV-TR criteria for Obsessive-Compulsive Disorder.
    b. Two patients with DSM-IV-TR diagnoses prototypically categorized as *hysterical symptoms* (i.e., without clear co-morbid obsessional/introjective symptoms)[8]. As further discussed in Chapters 4 – 5, one patient was diagnosed with Dissociative Identity Disorder (Chapter 4), the second patient with Conversion Disorder (Chapter 5).
2. For all four patients:
    a. Treatments were completed at the start of the present research project;
    b. Longitudinal data throughout treatment was available (see description of research material below);
    c. Patients had informedly consented to follow-up assessments.

Research Material

In order to meaningfully draw on observations from a case study, Stiles (2007) argued a rich case record, including both quantitative and qualitative data, to be essential. Accordingly, Jackson, Chui, and Hill (2011) stated that the depth of assembled data is paramount to confirmation or disconfirmation, and potential elaboration of existing theoretical statements. The use of multiple sources of evidence is described to augment case studies' "construct validity" (Yin, 1994, p.33).

Therefore, on each patient's symptomatic and interpersonal dynamics, data were obtained *regularly throughout treatment and follow-up*, from *multiple perspectives* (i.e., patient, therapist, researcher) and *multiple quantitative and qualitative sources* (see tables and further discussion below). As outlined above, different perspectives and sources each contribute unique perspectives on the variables under study, which have to be considered within the singular dynamics of each studied patient. In the present project, not one methodology or perspective is deemed superior over an other, but treated as a *valuable complement* to other data sources in providing a *differentiated assessment* of each patient's symptomatic and interpersonal functioning and emerging evolutions throughout therapy (see also Hill, 2012).

Hence, in order to critically weigh and integrate the different sources of information into a nuanced, rich and empirically sound assessment, a data-analytic approach is needed that simultaneously provides methodological rigor, while doing justice to the clinical complexity of the material. A detailed discussion on how the present doctoral project attends to this need is therefore provided in the following section on data-analysis (conducted by teams of researchers that were purposefully tailored and composited differently for case study).

[8] This type of selection is generally referred to as 'information-oriented case selection' (in contrast to a 'random selection'; Flyvbjerg, 2006).

Table 1
Qualitative material on patients' symptomatic and interpersonal functioning

Qualitative material				
Audio-recordings + verbatim transcripts of	Moment of collection	Conducted by	Audio-recorded by	Transcribed verbatim by
Diagnostic interview	Intake	Therapist - patient	Therapist	Researcher
Therapy sessions	Therapy	Therapist - patient	Therapist	Therapist
Semi-structured Change Interview	Follow-up measurement 1	Researcher - patient	Researcher	Researcher
Therapist session notes	Moment of collection: Intake, every therapy session, all follow-up measurements			

Note. Diagnostic interview = Structured Clinical Interview for DSM-IV-TR diagnosis; Supportive-Expressive Therapy is conducted according to the treatment manual of Luborsky (1984); Semi-structured Change Interview (SCI; Elliott, 1999; Elliott, Slatick, & Urman, 2001).

Table 1 presents the qualitative material for each case study on both symptomatic and interpersonal functioning to be comprised of patients', therapist's and researchers' narratives during intake, therapy and follow-up interviews. All therapy sessions and interviews were entirely (i.e., from patients' arrival at the consultation room until their departure) audio-recorded and subsequently transcribed verbatim (i.e., by one member of the research team, and subsequently checked for accuracy by another team member).

As psychopathology proves to be intrinsically interwoven with patients' overall sense of well-being, patients' symptomatic, general, interpersonal and occupational functioning is broadly questioned on psychological and physical level via a structured diagnostic interview (resulting in DSM-IV-TR diagnosis; APA, 2000), which might identify areas of concern that would otherwise not have been disclosed spontaneously by the patient.

In addition, therapist's session reports are collected to shed light on clinical impressions of patients' functioning and the ongoing working alliance. Impressions are primarily based on patients' (face to face) narratives and non-verbal conduct during treatment sessions (i.e., "the most direct and observable changes", Hill, Chui, & Baumann, 2013, p.75).

Further, the semi-structured follow-up interview provides a valuable opportunity for patients to assume a more reflective stance about the role therapy has played in their lives, and to construct their own responses concerning what has been important to them personally. This information can further deepen researchers' understanding by potentially learning things about subjectively experienced treatment processes they had not necessarily expected to learn.

In addition, quantitative data were gathered on both symptomatic and interpersonal functioning. Detailed descriptions of all presented measurements and the specific sessions/time points at which they were completed (which varies slightly between the studied patients) are provided in the Method sections of Chapters 2 – 5. Table 2 presents a general overview of the assembled data set for each patient.

Table 2
Quantitative material on patients' symptomatic and interpersonal functioning

	Quantitative material			
Perspective	Symptomatic functioning		Interpersonal functioning	
	Measure	Moment of collection	Measure	Moment of collection
Patient	General Health Questionnaire-12	Intake, every therapy session, all follow-up measurements	Inventory of Interpersonal Problems-32	Intake, every therapy session, all follow-up measurements
	Symptom Checklist-90-Revised	Intake, every eighth therapy session, all follow-up measurements		
Researcher	Global Assessment of Functioning scale	Intake, every eighth therapy session, all follow-up measurements	Global Assessment of Functioning scale	Intake, every eighth therapy session, all follow-up measurements
Impartial	Salivary cortisol concentration	Intake, every eighth therapy session, all follow-up measurements		
	Health care costs	From pre-treatment until last follow-up measurement		

Note. General Health Questionnaire - 12 (GHQ- 12; Goldberg, 1972; Koeter & Ormel, 1991); Symptom Checklist - 90 - Revised (SCL-90-R; Derogatis, Lipman, & Covi, 1973); Global Assessment of Functioning (GAF; APA, 1987); Inventory of Interpersonal Problems - 32 (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000); health care costs are retrieved via patients' health insurance fund.

Symptomatic Functioning.

In view of:

- psychodynamic broad and open notions of neurotic symptoms (i.e., as idiosyncratically shaped and expressed; e.g., Blatt, 1974, 2004, 2008; Luborsky, 1984; Vanheule, 2014), rather than clinging on to rigid pre-formulated outlines;
- our related aim to illuminate different aspects of patients' multifaceted symptomatic functioning,

we chose to define symptom in the present doctoral project as a dysfunction of a usually intact capacity that causes the patient (psychic and/or somatic) suffering.

First, symptomatic and general distress is assessed on various domains via self-report questionnaires (completed after the respective sessions in the consultation room, without interference by the therapist). This enabled the research team to conduct statistical analyses, construct visual graphs and compare results to norm groups. Moreover, items can illuminate specific contents that may not be readily revealed to the therapist in a direct fashion.

Syncronously, (based on patients' answers to the diagnostic interview and to questionnaire items, on their narratives during treatment and on therapist's session reports) researchers' views of patients' general, social and occupational functioning is obtained through assessment of the 'Global Assessment of Functioning'-scale (GAF; DSM-IV-TR, APA, 2000).

Independent from patients' and researchers' judgement, supplementary, more 'objective' scientific documention provides an additional unique perspective on patients' functioning and on therapy

progress that can critically nuance former judgements. Representing a biomarker of an activated stress response (e.g., Kirschbaum, Bartussek, & Strasburger, 1992), salivary cortisol concentrations are collected via saliva samples, i.e., for the patients studied in Chapters 2 and 4 (see Method sections of these chapters; salivary cortisol was not collected for the cases studied in Chapters 3 and 5). In addition, since symptomatic ill-being is frequently related to higher medical care utilization (e.g., Barsky et al., 2001b; Noyes et al., 1994) and occupational disability (e.g., Mykletun et al., 2009), health care cost information is retrieved (including all patients' medical and psychiatric consultations, hospitalizations, [psychotropic and other] medication use, and job absenteeism), spanning a wide pre- to post-treatment period.

Interpersonal Functioning.

In the present project, interpersonal functioning is accordingly considered as a multifaceted dynamic variable and, consequently, assessed through multiple means.

In accordance with Luborsky's (1962) and Blatt's (1974, 2004) theories described above, we specifically operationalized "interpersonal functioning" by means of the widely used Core Conflictual Relationship Theme method (CCRT; Luborksy & Crits-Christoph, 1998). This method offers a systemized, reliable and empirical supported means (e.g., Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2000) of making core conflicts in patients' narratives about relational exchanges operational, while staying close to the complexity of clinical experience. Moreover, in line with the Supportive-Expressive Therapies under study (SET; Luborsky, 1984), CCRT-methodology provides conformity between the treatments as conducted by the therapist, and the researchers' method of analyzing the narrative data extracted from this treatment.

Patients' CCRT's are systematically identified and formulated through subsequent steps (see Method sections of Chapters 2 – 5) based on 'Relationship Episodes' (RE's), selected by the research team in patients' narratives during sessions. RE's are defined as discrete episodes in which patients disclose spontaneously (i.e., not in answer to a specific question by the therapist pertaining to [a part of] the CCRT) about a concrete relational exchange (Luborksy & Crits-Christoph, 1998).

Yet, in view of our research aims to capture potential, unexpected complexities, analysis of patients' interpersonal functioning throughout therapy was not confined to merely placing preimposed categories on the narrative data. In the exploratory part of the study (see section on concrete data-analytic steps below), all patients' narratives about his/her relational experiences are considered (i.e., not only the narratives that neatly fall within the preset demarcations of what applies as RE according to Luborsky and Crits-Christoph, 1998), e.g., also described characterizations of specific others or the other in general.

Then, in addition to data provided by researcher-rated 'Global Assessment of Functioning' and the Semi-structured Change Interview described above, further insight into patients' interpersonal functioning is obtained by data from a self-report questionnaire (likewise completed after the respective sessions in the consultation room, without interference by the therapist). The widely used and empirically supported Inventory of Interpersonal Problems (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000) yields a total score on interpersonal malfunctioning, and additionally allows to calculate

specific hysterical/dependent and obsessional/autonomous subprofiles, for which a scoring system was developed by Desmet et al. (2008).

Specific Research Questions and Predictions

Blatt's (1974, pp. 155-157) symptom specificity hypothesis predicts specific modes of interpersonal functioning (i.e., prototypically dependent/anaclitic or autonomous/introjective) to be related to specific types of neurotic symptoms (i.e. prototypically hysterical or obsessional).

In order to draw up concrete predictions concerning the interpersonal behavior expected to be displayed by the two pairs of patients under study, we specifically translated Blatt's theoretical statements about typical characteristics related to dependent/anaclitic and autonomous/introjective interpersonal dynamics, into Core Conflictual Relationship Theme components, using the standardized coding system (which conveniently allows for calculation of proportions of agreement between different research team members; Standard Category List, Edition 2; Luborksy & Crits-Christoph, 1998, p.26).

In line with the 'consensus process' as a vital part of Consensual Qualitative Research methodology (CQR; Hill, 2012) described below, these specific operationalizations were formulated by one member of the research team, and subsequently checked for accuracy and completeness by other team members until all consented on the most faithful representation of Blatt's (1974, 2004) theory. (Specific details concerning the consensus process in research teams and handling of divergence and disagreement are rendered in the section on data-analysis below).

Hence, operationalizing interpersonal characteristics by means of the CCRT-method, the classical symptom specificity hypothesis leads up to the following expectations with respect to symptomatic-interpersonal associations in the patients under study (see Tables 3 – 4):

Table 3
Hypotheses and predictions concerning symptomatic-interpersonal associations before the onset of therapy (hypothesis-driven part of the research project)

Obsessional symptoms	Hysterical symptoms
Before the onset of therapy (during the intake phase) we expect symptoms will be accompanied by:	
Autonomous interpersonal style expressed in exaggerated emphasis on ▪ definition of self as distinct from others ▪ separation from others	Dependent interpersonal style expressed in exaggerated emphasis on ▪ interpersonal relatedness ▪ closeness to others
Quantitatively, we expect:	
Higher autonomous (than dependent) interpersonal sub-profile on IIP-32	Higher dependent (than autonomous) interpersonal sub-profile on IIP-32
Qualitatively, we expect the following CCRT-components to underpin patients' relational exchanges:	
Wishes	
To be independent, be my own person, have (self-) control, assert oneself, be acknowledged, be respected, achieve	To be respected, be liked, be dependent, be close, have trust, help, be helped, avoid rejection, not be hurt
Responses of Other	
Critical, controlling, opposing, not respectful	Distant, not accepting, hurting, not trustworthy, not cooperative, disliking
Responses of Self	
Feelings of anxiety, self-doubt, uncertainty, guilt, failure, depression, (struggles with) anger and/or aggression, vengeful fantasies	Feelings of dependency, uncertainty, disappointment, depression, anxiety, being unloved

Note. IIP-32 = Inventory of Interpersonal Problems questionnaire with 32 items; Scoring system for calculation of specific hysterical/dependent and obsessional/autonomous subprofiles is developed by Desmet et al. (2008); Predictions concerning prevailing IIP-32 sub-profiles are based on Desmet, Meganck, and Vanheule (2013); CCRT = Core Conflictual Relationship Theme (Luborksy & Crits-Christoph, 1998); Predicted CCRT-components are formulated on the basis of Standard Category List, Edition 2 (Luborksy & Crits-Christoph, 1998, p.26); Wishes = needs or intentions with which patients enter interpersonal exchanges; Responses of Other = patients' appraisals of how the other person responds to these wishes; Responses of Self = patients' own subsequent responses (Luborksy & Crits-Christoph, 1998).

Table 4
Hypotheses and predictions concerning symptomatic-interpersonal associations throughout the therapeutic process (hypothesis-driven part of the research project)

Obsessional symptoms	Hysterical symptoms
Throughout the therapeutic process, we expect:	
▪ SET will reduce patients' exaggerated strivings towards autonomy and independence *from* others, and their related expense or neglect of installing interpersonal relatedness ▪ Obsessional symptoms will subsequently diminish	▪ SET will reduce patients' exaggerated strivings towards interpersonal relatedness, and their related expense or neglect of developing a well-defined consolidated sense of self distinct from others ▪ Hysterical symptoms will subsequently diminish
Quantitatively, we expect progressively decreasing scores on symptoms and general distress will positively and significantly be correlated with progressively decreasing scores on:	
IIP-32 autonomous profile	IIP-32 dependent profile
Qualitatively, we expect changes in (intensity/content/form of) symptoms will be accompanied (and preceded) by changes in:	
Autonomous CCRT-components	Dependent CCRT-components

Note. SET = Supportive-Expressive Therapy, conducted according to the treatment manual of Luborsky (1984); CCRT = Core Conflictual Relationship Theme (Luborksy & Crits-Christoph, 1998); Both for patients with obsessional as for patients with hysterical symptoms, CCRT-changes are particularly expected in Response of Others and Response of Self components, as previously evidenced by, e.g., Crits-Christoph and Luborsky (1990), Grenyer and Luborsky (1996).

Data-Analytic Approach

Data-analysis included three main steps. Step 1 and 2 encompass a quantitative and qualitative outline of evolutions in patients' symptoms (Step 1) and interpersonal functioning (Step 2) throughout therapy and follow-up. In Step 3, associations between patients' symptomatic and interpersonal functioning were quantitatively and qualitatively described, and embedded within a broader, clinical description of the therapy process (i.e., 'thick description'; Pontoretto & Grieger, 2007; see discussion of 'Concrete Data-Analytic Steps' below).

All three steps are 'thickly' described per case study in the sections on data-analysis in Chapters 2 – 5 (as explicitly advocated by Ponterotto and Grieger, 2007, in order to arrive at high quality reports and establish "trustworthiness"). In this part, we discuss our choice for Consensual Qualitative Research for Case Studies (CQR-C; Jackson, Chui & Hill, 2011) as overarching framework for our analyses of quantitative and qualitative case materials; how we specifically applied this approach in the present project; and the measures we have taken to curtail biases and subjectivity inherent to the interpretation process, as a means of enhancing the 'credibility' (Morrow, 2005) and 'trustworthiness' (e.g., Elliott, Fischer, & Rennie, 1999; Hill, 2012) of findings and conclusions.
The concurrent use and analysis of quantitative and qualitative data in the present research project is generally referred to as 'concurrent triangulation research design' (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005), described as:

> "In concurrent triangulation designs, quantitative and qualitative data are collected and analyzed at the same time. Priority is usually equal and given to both forms of data. Data analysis is usually separate, and integration usually occurs at the data interpretation stage. Interpretation typically involves discussing the extent to which the data triangulate or converge" (p.229).

Consensual Qualitative Research as Overarching Data-Analytic Approach

The richly gathered data set on the variables under study inevitably places a difficulty on fluently organizing all (con- and divergent) findings into integrated, nuanced and empirically sound conclusions pertaining to the research questions presented above. In order to reduce individual biases resulting from the sole viewpoints of single researchers in analyzing the data, and to establish methodological rigor as well as depth, we deliberately chose Consensual Qualitative Research (CQR; Hill, 2012) adjusted for Case Studies (CQR-c; Jackson, Chui & Hill, 2011) as data-analytic approach. CQR-c is precisely developed to assess clinical complexity of intricate social science phenomena throughout the course of therapy. Based on an extensive methodological review, Ponterotto (2005) reported CQR to be one of the most frequently used qualitative inquiry approaches over the past decades in psychotherapy research. Iwakabe (a prominent contemporary author on case research methodology) explicitly recommended CQR (Iwakabe, 2011; Iwakabe & Gazzola, 2009) in both systematic single case research, as cross-case comparison, aimed at theory building and development.

CQR-c is built on a number of key concepts that particularly pertain to the present research aims and assembled dataset. In particular, case materials are thoroughly examined in a specifically composited research team. Sound triangulation and interpretation of a broad set of quantitative and qualitative data requires an array of theoretical, methodological and clinical knowledge. Generally, one person proves unable to exhibit expertise in all areas (see also Iwakabe, 2011). Moreover, as interpretation level is usually high "in the process of making meaning out of people's stories" (Hill, 2012, p.9), a well-selected team of researchers with differing expertise is paramount in countering individual biases.

CQR-c is specifically centered on the 'consensus process', i.e., the triangulation of different viewpoints on the data through multiple gatherings, in which team members question each others' ideas, interpretations and nuances of the data. Each member is invited to fully express his/her interpretations of the data, and in-depth discussion between members on how different data sources complement and/or contradict each is explicitly installed. Consequently, different viewpoints emerge and a scientific surplus value is provided through a rich, thorough and constructive understanding of the complex phenomena under study (Dattilio, Edwards, & Fishman, 2010), which is pivotal to high-quality case reports (McLeod, 2013). Yin (1994) advances the systematic weighing of rival explanations of the data as a valued means of augmenting case studies' *internal validity*. In case of

disagreement during team meetings, researchers challenge each other on their ideas, until all members agree on the best representation of the data (i.e., "consensus"; in contrast to merely gluing together different views or reaching forced, disjoint decisions).

'*Credibility*' (Morrow, 2005) and '*trustworthiness*' (i.e., the qualitative equivalent of the quantitative concept of "validity"; e.g., Elliott, Fischer, & Rennie, 1999; Hill, 2012) of the team's emerging understanding is enhanced by a constant, critical intercommunion between the raw data (bottom-up) and an operational set of guiding theoretical statements (top-down); and by paying special attention to a number of advisory guidelines. Particularly recommended is a clear description of both methods and results; the use of multiple methods for collecting data; staying close to the raw data in striving for a balance between "what the participants say and how the researchers interpret their responses" (Hill, 2012, p.179), e.g., by providing sufficient contextual detail and reciting patients' literal wordings to illustrate researchers' remarks in 'thick descriptions' (Pontoretto & Grieger, 2007; see below); explicit exploration and management of individual biases and expectations (i.e., 'reflexivity'; Rennie, 2004); a clear communication of the findings and their applicability to broader theoretical issues, past research and practice.

CQR methodology, followed by thick description, is commonly used in (psychotherapy) research that simultaneously relies on quantitative and qualitative data (e.g., Hanson, Creswell, Plano Clark, Petska, and Creswell, 2005). It is explicitly described to be a *flexible* approach that has to be *tailored* according to the particular research project, aims and questions (Hill, 2012). Hence, in the next section, we present how we concretely applied CQR-c in our analyses of the assembled quantitative and qualitative data, and which measures we took to explore and manage individual biases throughout the data-analytic process.

Concrete Data-Analytic Steps and Methodological Considerations

For each empirical case study (Chapters 2 – 5), and for the synthesis of findings across all case studies (General Discussion), quantitative and qualitative data were analyzed and triangulated within a research team. *Specific composition* of the team*s* varied between the studies (see Method sections of Chapters 2 – 5 and General Discussion). Dependent on the specific topic at hand (i.e., obsessional neurotic symptoms [Chapters 2 – 3], dissociative identity disorder [Chapter 4], or conversion disorder [Chapter 5)], team members were deliberately blended to incorporate *varying degrees of theoretical, methodological and clinical expertise*, i.e., to help ensure contribution of various meaningful perspectives. Yet, as a prerequisite for each study, all team members had received psychotherapeutic training and were (basically) familiar with the theoretical orientation and phenomena of interest.

In order to answer the research questions pertaining to the hypothesis-driven parts of the studies, and formulate empirically sound conclusions relating to the discovery-oriented parts, data-analyses comprised the following steps.

In Step 1, one member of the research team (below referred to as 'researcher 1') inputted the data of self-report questionnaires, and constructed graphs (see Figures in Chapters 2 – 5 and General Discussion) on quantitative evolutions in all outcome measures of symptoms and general well-being. To assess significance of change, the ACORN Toolkit (specifically designed to help clinicians and researchers calculate change related statistics for a variety of outcome measures; Brown, Simon, Cameron, & Minami, 2015) was used to calculate

- Reliable Change Indices (RCI; identical to RCI formula of Jacobson and Truax, 1991, but with one-tailed 95% confidence intervals; see Brown et al., 2015)
- Severity Adjusted Effect Sizes (SAES; Brown et al., 2015).

Data input, construction of graphs, and calculation of RCI's and SAES's were checked for accuracy by a second team member, and, if necessary, corrected.

Next, two research team members (i.e., 'researchers 1 and 2') attentively listened to audiotapes and read the transcripts. Both were equally informed of relevant patient demographic information and therapy characteristics (see Hill, 2012), but researcher 2 was blind to the quantitative graphs. Both researchers separately identified all events where the patient explicitly referred to his symptoms, and marked symptomatic evolutions throughout therapy with respect to intensity, content or form. Through subsequent discussion on the most profound changes, consensus was reached on identification of the main 'tipping points' (i.e., specific moments in the chronicle of events that turn out to be crucial for further development; Tarrow, 2004). A concise qualitative description of symptomatic evolutions was provided by researcher 1, reviewed by two other team members (of which one was familiar with the raw narrative data), and consequently refined.

In Step 2, researcher 1 constructed similar graphs on evolutions in interpersonal characteristics throughout therapy (see Figures in Chapters 2 – 5 and General Discussion), depicting IIP-32 total, dependent and autonomous scores (see Vanheule, Desmet, & Rosseel, 2006). Again, RCI and SAES were computed using the ACORN Toolkit (Brown et al., 2015) to assess significance of change; and data input, construction of graphs, and calculation of RCI's and SAES's were checked for accuracy by a second team member, and, if necessary, corrected.

Next, researchers 1 and 3 conducted CCRT analyses for the first therapy sessions, the 'tipping point'-sessions selected in Step 1, and the last sessions. In a first phase, both researchers attentively re-read transcripts of the identified sessions, individually selected all RE's that were suitable for CCRT coding (i.e., RE's that contained W's, RO's and RS's), and gathered to select by consensus the 10 most informative RE's. When sessions yielded less than 10 informative RE's, additional RE's were selected from the preceding and/or following sessions. In a second phase, selected RE's were written down in a separate document and coded using the standardized coding system (Standard

Category List, Edition 2; Luborsky & Crits-Christoph, 1998, p.26). In line with Hill et al. (2011), judges distinguished between:

- RE's describing interactions with
  - *specific people*
  - *people in general*
- W's, RO's and RS's occurring in
  - *all* RE's (General, G)
  - *at least half* of RE's (Typical, T),
  - *less than half, but at least two* RE's (Variant, V).

Then, researcher 1 organized consensus CCRT-codes in tables (see Tables in Chapters 2 – 5 and General Discussion), which were checked for accuracy and comprehensiveness by researcher 3. Brief clinical descriptions of all presented relationships were provided by researcher 1, reviewed by two other team members (of which one was familiar with the raw narrative data), and consequently refined.

In Step 3, researcher 1 calculated longitudinal intra-subject associations (i.e., correlations between two series of repeated measures within the same subject) between evolutions in patient's symptomatic, general and interpersonal level of functioning. Calculation was checked for accuracy by another team member and, if necessary, corrected

Next, researcher 1 engaged in a "thick description" (Pontoretto & Grieger, 2007) of the longitudinal, clinical interplay between both levels throughout therapy, in which changes in quantitative measures were linked to the treatment narrative (Dattilio, Edwards, & Fishman, 2010), and significant therapist interventions and extra-therapeutic events were discussed. In line with psychodynamic orientation (e.g., Blatt, 2004; Vanheule 2014), specific attention was paid to the symptom's *function* within the patient's interpersonal functioning, which enabled to examine aspects of therapeutic change that are often ignored or overlooked in symptom-focused approaches to psychotherapy research (Blatt & Auerbach, 2003). Further, in view of:

- the projects' discovery-oriented research aims (to potentially discover features that were not readily included in the research questions and predictions, and that might lead to theory development through proposed extensions and/or modifications),
- the related endeavored appeal to (clinically oriented) scholars and clinicians (who principally work with patients' gradually disclosed, subjective experiences), as the starting-point theoretical statements under study (Blatt, 1974, 2004) are foremost formulated to inform and guide clinical practice,

we deliberately chose to organize this thick description by means of chronologically and progressively giving out information as it was revealed by the patient to the therapist throughout the successive sessions. In other words, structure was primarily introduced by the rhythm of the ongoing therapeutic process between patient and therapist, and the (mutual) gradual increase of

understanding and meaning as new material progressively emerged; i.e., rather than solely dictated by a researcher perspective that focuses on specific themes across various therapy sessions.

In order to translate research findings into actual clinical practice, Information about specific mechanisms of change and about impacting therapeutic factors are what clinicians are most interested in (Iwakabe & Gazzola, 2009). Flyvbjerg (2006) explicitly advizes *against* summarizing dense case studies into a few main results, as dense descriptions are both more useful for clinicians *and* more interesting for social theory. Instead of assuming the role of omniscient narrator and summarizer, researchers should describe the process in its diversity and allow it to unfold over the many-sided complex stories.

Finally, in the General Discussion of this doctoral dissertation, findings from the hypothesis-driven and discovery-oriented parts of the four case studies are compared, integrated and synthesized in the form of a multiple case study (Yin, 1994). In case comparisons, Iwakabe and Gazzola (2009) distinguish between 'multiple case studies' and 'meta-studies/meta-syntheses'. Rather than reanalyzing published materials on the primary researchers' constructions (as is the case in metasyntheses), our cross-case analysis deals with the primary data sources and, therefore, qualifies as a multiple case study.

In this discussion, the four empirical case studies (Chapters 2 – 5) are systematically juxtaposed by researcher 1 (both within, between and across pairs of similarly diagnosed cases), to identify and articulate similarities, repeated observations or common themes, as well as differences and significant idiosyncrasies of each case; both in manifest constructs as in underlying dynamics.

Con- and diverging findings were critically integrated and discussed in light of the starting-point hypotheses and research aims, and of current theoretical, methodological and clinical knowledge and practice (see Iwakabe & Gazzola, 2009).

Especially for the 'thick description' in Step 3 of each case study (i.e., Chapters 2 – 5) and the cross-case analysis (i.e., General Discussion), several precautions were taken to reduce researcher 1's biases and expectations, and to help ensure a "truer" account of the data (see Hill, 2012):

- Prior to writing, researcher 1 orally presented provisional analyses to other research team members (of which minimum one was unfamiliar with the case data, but acquainted with the theoretical orientation and phenomena of interest, and equally informed about the research questions), who extensively questioned her in order to focus findings more clearly in response to the research questions;
- During the writing process, researcher 1 continually returned to raw materials to stay close to the patient's narratives, and included sufficient contextual detail and literal quotes of the patient to support presented findings,
    - as explicitly recommened in recent work on beneficially communicating qualitative research findings (Goldberg & Allen, 2015; Ponterotto & Grieger, 2007); and
    - to enable readers to assess the findings' "intersubjective nature", i.e., to what extent they would arrive at similar conclusions and interpretations of the presented data

(e.g., Fischer, 1999, p.109; McLeod, 2011; Ponterotto & Grieger, 2007).

- Finally, each manuscript (Chapters 2 – 5 and General Discussion) was reviewed several times by other team members (of which one was unfamiliar with case data and research questions) to identify areas in need of further attention; which were subsequently refined.

Building on cited methodological precautions, we would like to conclude this General Introduction by recapitulating the different measures we have taken throughout the research process to strengthen the studies' methodological rigor (based on Yin, 1994, pp.32-38) and theoretical and clinical value (e.g., Ponterotto & Grieger, 2007).

First, we documented the project's *'social validity*'[9] by addressing the rising dissatisfaction amongst clinicians and social science researchers concerning the large amount of isolated diagnostic categories and the latter's limited clinical applicability (see Vanheule, 2014, for a comprehensive argumentation). In order for psychodiagnostics to become more effective (i.e., better guide clinical practice), we pointed to the need for meaningful reductions within the diversified field of neurotic symptoms, and fingered a valuable, highly studied attempt in this direction, i.e., Blatt's clinical theory on anaclitic/dependent and introjective/self-critical/autonomous configurations, and its specific operationalization as the symptom specificity hypothesis (1974, pp. 155-157). Starting from marked inconsistency in previous findings on this theory, we argued the present project's theory-building aims through potential hypothesis-refinement (Stiles, 2009, 2015).

To augment the studies' '*construct validity*' (Yin, 1994, p.34-35), we assembled a rich dataset that relied on multiple sources of quantitative and qualitative materials, gathered from multiple perspectives, and collected longitudinally at regular intervals from (pre-)treatment until multiple follow-up measurements. For the quantitative data, empirically supported measures and analyses were chosen. For the qualitative data, and the triangulation of qualitative and quantitative data, we explicitly engaged different research team members (explicitly recommended by e.g., Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005; Hill, 2012) with varying degrees of theoretical, methodological and clinical expertise in each data-analytic step (including regular reviews of evolving drafts for each single and multiple case study report; see Yin, 1994, p.33).

As Yin (1994, p.35) points out, the concept of '*internal validity*' is strictly only applicable to *causal* case (and group) designs, yet, may be extended to the broader problem of making *inferences* (which apply to statements on events that cannot be directly observed); see the related concept of 'trustworthiness' (e.g., Elliott, Fischer, & Rennie, 1999; Hill, 2012) of presented findings and conclusions. To enhance the studies' 'internal validity', we established 'triangulation' (e.g., Hill, 2012; Yin, 1994) between different data sources, competing perspectives, and critical intercommunion between a guiding operational set of theoretical statements and a constant return to the raw data. This triangulation process took place during multiple team meetings, in which individual biases and expectations were explored and managed (i.e., '*reflexivity*'; Rennie, 2004) through in-depth

[9] "Social validity is described by Morrow (2005) and Ponterotto and Grieger (2007) as a criterium to enhance a study's "trustworthiness". It refers to the social value and importance of the research topic to the profession and the society at large (e.g., Ponterotto & Grieger, 2007, p.414).

discussions, until all team members unanimously agreed on the best representation of the findings, i.e., "consensus process" (Hill, 2012). Together with 'thick', systematic descriptions of methodological considerations and data-analytic steps (see Ponterotto & Grieger, 2007), this consensus process contributes to the studies' '*reliability*' (Yin, 1994) and '*credibility'* (Morrow, 2005).

In the context of '*external validity*' (often a traditional prejudice against case study research), i.e., "the problem of knowing whether a study's findings are generalizable beyond the immediate case study" (Yin, 1994, pp.35-36), '*analytical generalization*' needs to be distinguished from 'statistical generalization', which are two alternative types of scientific generalization (Yin, 1994). Rather than striving towards generalization of the results to broader populations or universes (i.e., to enumerate frequencies; statistical generalization), case studies strive to transfer results to theoretical propositions (i.e., to expand or modify established theories; analytical generalization). In the present project, each case study endeavors to contribute to theory building (see also Stiles, 2009). In addition, if particular findings prove to be recurrently observed under similar, but inherently different circumstances during the cross-case analysis, results from the multiple case study further strengthen '*transferability'* (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005) of findings to theory building.

Finally, by:

- inclusion of contextual detail (e.g., clear descriptions of therapist interventions and extra-therapeutic events that influenced ongoing change mechanisms) and patients' literal wordings, into so-called 'thick descriptions' (Pontoretto & Grieger, 2007) of the therapy process,
- clear communication of the findings and their applicability to the starting-point theoretical statements, past and future research and clinical practice,

'reliability' and '*credibility'* of the presented findings and conclusions is enhanced, and clinicians are more able to judge whether the discussed dynamics are applicable to their own practices and settings (i.e., *external validity*).

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2

EMPIRICAL CASE STUDY 1

INTERACTIONS BETWEEN OBSESSIONAL SYMPTOMS AND INTERPERSONAL DYNAMICS THROUGHOUT PSYCHODYNAMIC PSYCHOTHERAPY:

A FIRST CASE OF OBSESSIVE-COMPULSIVE DISORDER[10]

Both classical and contemporary psychoanalytic theories stress the importance of interpersonal dynamics in diagnosing and treating neurotic symptoms. Associations between the symptomatic and interpersonal level of subjective functioning have formally been represented in the symptom specificity hypothesis (Blatt, 1974). This hypothesis specifically links obsessional symptoms to an interpersonal style directed at autonomy and separation from others. However, findings from previous cross-sectional group studies on symptom specificity do not converge, which possibly indicates that the complexity of symptom-interpersonal associations is underestimated.

This chapter presents an empirical case study specifically aiming at refinement of the classical symptom specificity hypothesis. Consensual Qualitative Research for Case studies is used to quantitatively and qualitatively describe the longitudinal, clinical interplay between obsessional symptoms and interpersonal dynamics throughout the process of supportive-expressive psychodynamic therapy. Findings affirm a close association between symptoms and interpersonal dynamics. Unexpectedly, however, obsessional symptoms prove to be determined by profound ambivalences between dependent and autonomous interpersonal behavior, occurring both within and between significant relationships. Psychodynamic interventions focusing on core relational conflicts are related to interpersonal and symptomatic transformations. Findings are discussed in light of conceptual and methodological considerations; limitations and future research indications are addressed.

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[10] This chapter is based on Cornelis, S., Desmet, M., Meganck, R., Cauwe, J., Inslegers, R., Willemsen, J., Van Nieuwenhove, K., Vanheule, S., Feyaerts, J., & Vandenbergen, J. (2016). Interactions between obsessional symptoms and interpersonal dynamics: An empirical single case study. *Psychoanalytic Psychology*. Advance online publication. doi: http://dx.doi.org/10.1037/pap0000078

Introduction

Psychoanalytic theory has always stressed the centrality of interpersonal dynamics to the emergence and maintenance of psychic illness. An important focus of psychodynamic research has consequently been on the identification and description of specific relationship patterns, and their associations with symptomatology. In this respect, the symptom specificity hypothesis (Blatt, 1974, pp. 155-157) discerns two major interpersonal styles that are distinctly associated with different types of neurotic symptoms. On the one hand, the *autonomous* style is hypothesized to be associated with obsessive-compulsive symptoms (e.g., obsessional ideas, compulsions, pathological doubt, inhibition), which are viewed as exaggerated attempts to install a sense of self-definition and separation from others. The *dependent* style, on the other, is related to bodily symptoms (e.g., somatization and conversion reactions) and phobias, considered as exaggerated attempts towards closeness to significant others. Over the past decade, Blatt's symptom specificity hypothesis has been put to the test in several cross-sectional group studies, which yielded markedly inconsistent findings, both in clinical and in nonclinical samples (for a review, see Desmet, 2007).

The lack of converging results might be due to several conceptual and/or methodological issues related to the nomothetic research designs of these studies. *Conceptually,* the classical symptom specificity hypothesis has necessarily been reduced to less complex statements that were suitable for testing in cited designs. Hence, the tested operationalizations potentially yielded an underestimation of the complexity of associations (see also Desmet, 2013). Importantly, Blatt's theory primarily aimed at defining complex clinical interplays between symptoms and interpersonal characteristics over time. *On a methodological level*, therefore, pertinent investigation into these dynamics actually requires longitudinal clinical data, in which co-variations between both levels can be observed over time or in the course of a therapy process. Still, up until now, all studies on symptom specificity (1) were cross-sectional in nature (i.e., relying on measurements of symptomatic and interpersonal features at one single time point) and, consequently, described static associations; (2) defined average, invariant tendencies in (large) groups of participants, resulting in rule-based, abstract knowledge that disregards intra-individual variability and (potentially relevant) contextual factors as confounds; consequently, it is unable to readily capture the multiple and dynamic factors operating in real-world clinical practice (e.g., Vanheule, 2014); (3) used solely quantitative, patient-reported measurement of participants' symptomatic and interpersonal functioning, which are known to be subject to a variety of biases (e.g., Desmet, 2007; Schwarz, 1999).

Hence, rather than aiming at additional statistical testing of the classical symptom specificity hypothesis, there might first be need to *refine* it on some points. Empirical case research specifically allows for hypothesis-refinement, as it covers important areas that might be overlooked in nomothetic designs (Iwakabe & Gazzola, 2009). In order for theories to be clinically useful, they need to account for (1) *patterns* amongst the complexity of psychotherapeutic processes, and (2) specific *variations*,

and the applicability of group-based findings to *idiographic* contexts of every-day clinical practice, where multiple dynamic factors operate in ongoing processes (in which research consumers prove to be particularly interested, e.g., Flyvbjerg, 2006; McLeod, 2013; Stiles, 2009). In integrating (intra- and extra-therapeutic) contextual influences into thick descriptions of naturally unfolding processes over time, empirical case studies provide a distinctive, unique way of contributing to scientific development and the advancement of clinical knowledge (McLeod, 2013).

Aims and hypotheses

Addressing the methodological and conceptual issues raised above, the aim of the present 'theory-building' case study (Stiles, 2009) is to suggest areas where the classical symptom specificity hypothesis (Blatt, 1974, 2004) possibly needs to be *refined*, in order to be closer to both the complex theoretical underpinnings as to clinical dynamics. Symptom specificity is tested, therefore, in an empirical case study of a patient with obsessional complaints, who was treated in a real-world clinical practice by means of supportive-expressive psychodynamic therapy (Luborsky, 1984). The aim of the study is two-fold: (1) to test concrete operationalizations of the classical symptom specificity hypothesis (see below), and (2) to thoroughly investigate the dynamic unfolding of associations between the patient's symptomatic and interpersonal functioning throughout therapy. The additional discovery-oriented nature of the study thus scopes for the detection of distinctive, unexpected findings, which could indicate where the classical hypothesis possibly needs to grow. In doing so, we address both recommendations of earlier research on symptom specificity to make use of longitudinal designs (e.g., Pilkonis, 1988) in mental health clinical settings (e.g., Huprich, Rosen, & Kiss, 2013; Werbart & Forsström, 2014), and broader claims in psychotherapy research to direct research endeavors towards the increased use of idiographic research (e.g., Barlow & Nock, 2009; Dattilio, Edwards & Fishman, 2010; Hill, 2012; Iwakabe & Gazzola, 2009; McLeod, 2013; Stiles, 2009; Vanheule, 2014).

In order to enhance the 'credibility' (Morrow, 2005) and 'trustworthiness' (e.g., Elliott, Fischer, & Rennie, 1999; Hill, 2012) of the study, Consensual Qualitative Research for Case Studies (CQR-c; Jackson, Chui and Hill, 2011), was used as an overarching data-analytic approach. This well-established, systematic method was specifically developed to assess clinically rich and complex material, by addressing the data through different perspectives in a team of researchers. During multiple team meetings, systematic, in-depth discussion between team members on how different data sources complement and/or contradict each is explicitly installed, until all team members agree on the best representation of the data (Hill, Thompson, & Williams, 1997). The consensus process thus serves as a means of triangulating the researchers' understanding of the data. Moreover, critical intercommunion between theory (deductive) and data (inductive) results in a more meaningful understanding of the studied phenomena (Dattilio, Edwards, & Fishman, 2010), which is pivotal to high-quality case reports (McLeod, 2013).

To systematize empirical investigation of interpersonal behavior, 'Core Conflictual Relationship Theme' methodology (CCRT; Luborsky & Crits-Christoph, 1998) was used. This method is specifically based on Luborsky's (1962) theory that an individual's relational exchanges are underpinned by a typical 'core conflict'. As symptoms are claimed to be rooted in this core conflict, Luborsky (1962, 1984) theorized that psychotherapeutic endeavours aiming at transforming this conflict will bring about symptomatic changes; as previously evidenced by e.g., Grenyer and Luborsky (1996), Luborsky and Crits-Christoph (1998), and Slonim, Shefler, Gvirsman, and Tishby (2011). Hence, in line with the supportive-expressive therapy under study, CCRT-methodology provides conformity between the treatment as conducted by the therapist, and the researchers' method of analyzing the narrative data extracted from this treatment. Moreover, it allowes for reliable and systematic analyses (e.g., Wilczek, Weinryb, Barber, Gustavsson and Asberg, 2000), while staying close to the complexity of clinical experience.

Further, in order to optimize the possibility of capturing intended complexities, and to illuminate distinct aspects of (the broad spectrum of possible changes in) the variables under study (e.g., Hill, Chui, & Baumann, 2013), extensive multiple method and multiple source data sets were gathered. Symptomatic and interpersonal functioning, and their associations, were assessed regularly throughout treatment and during follow-up, in both a quantitative and qualitative fashion, from the perspectives of patient, therapist and researchers (see 'Procedure'). Symptoms and associated mental distress were additionally mapped via saliva cortisol concentrations (i.e., biomarker of distress) and health care costs (i.e., all mental and physical health related expenses, and job absenteeism; see Method). As such, clinical judgment, which is primarily based on the patient's (face to face) narratives and non-verbal conduct during treatment sessions ("the most direct and observable changes"; Hill, Chui, & Baumann, 2013, p.75), could importantly be nuanced by the gathering of additional, more 'objective' information on therapeutic progress. Quantitative measurements offer insight into the amount of symptomatic, general and interpersonal problems at various moments during therapy. Yet, predetermined items on standardized measures are at risk of not accurately reflecting a patient's subjective experience of well-being (Hill, Chui, & Baumann, 2013), which does not always coincide with a mere reduction in symptomatic and/or interpersonal problems. In this respect, qualitative study of the patient's narratives during sessions rendered additional, contextualized documentation.

Hence, operationalizing interpersonal characteristics by means of the CCRT-method, the classical symptom specificity hypothesis (Blatt, 1974, pp. 155-157) leads up to the following **predictions** with respect to symptomatic-interpersonal associations in the patient under study:

H1: Before therapy (during the intake phase) we expect the obsessional symptoms to be accompanied by an autonomous interpersonal style, expressed in an exaggerated emphasis on self-definition and separation from others.

H1a: Quantitatively, we expect the patient will show an autonomous sub-profile on the Inventory of Interpersonal Problems (IIP-32), rather than a dependent sub-profile (see Desmet, Meganck & Vanheule, 2013)

H1b: Qualitatively, we expect the following CCRT-components (Luborsky & Crits-Cristoph, 1998) to underpin the patient's relational exchanges: Wishes (with which he enters exchanges) = independence, self-control, self-assertion, being acknowledged and respected, achieving; Responses of Other (i.e., his appraisal of how the other person responds to these wishes) = critical, controlling, opposing, not respectful; Responses of Self (i.e., his own subsequent responses) = anxiety, self-doubt/uncertainty, guilt, feelings of failure, (struggles with) aggression, vengeful fantasies.

H2: Throughout the therapeutic process, we expect that the supportive-expressive therapy will reduce the exaggerated strivings towards autonomy and that, as a consequence, obsessive-compulsive symptoms will diminish.

H2a: Quantitatively, we expect that scores on the IIP-autonomy profile will decrease progressively throughout therapy and that the decreasing IIP-scores will be correlated with decreasing scores on symptoms and general distress

H2b: Qualitatively, we expect that changes in the autonomous CCRT's throughout therapy (particularly in the RO- and RS- components, e.g., Crits-Christoph & Luborsky, 1990; Grenyer & Luborsky, 1996) will be accompanied by changes in the obsessive-compulsive symptoms.

Method

Participants

The patient was a 29-year old Caucasian man. He was a secondary school graduate and a blue-collar worker, who was referred by his general practitioner due to intrusive obsessions. At intake, he met *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) criteria of Obsessive-Compulsive Disorder (axis I; no personality disorder was diagnosed on axis II). Patient provided written informed consent (approved by the University Ethics Committee) to participate in the study and to publish the individual case materials. All possibly identifying information has been changed to protect confidentiality.

The therapist was a 36-year old Caucasian, man, who held a PhD in clinical psychology, received three-year postgraduate training in Freudian-Lacanian psychoanalytic psychotherapy, and had six years of clinical experience at the start of therapy.

The research team consisted of one female assistant professor, two postdoctoral researchers (one male, one female), and two PhD students (one male, one female). They were all Caucasian, ranged in age 24-35 years, and were trained in Freudian-Lacanian psychoanalytic psychotherapy.

Therapy

Patient received 22 (40- to 60-minute) sessions of supportive-expressive psychoanalytic

psychotherapy (Luborsky, 1984) over 11 months, conducted in the therapist's private practice without interference of the research team. Session frequency varied between once a week and once every month, with an average frequency of one session every two weeks (see Figure 1). In-depth discussion of the therapeutic process, including specific examples of supportive and expressive techniques, is provided in Results Step 3.

Measures

Symptoms and General Well-Being.

Idiosyncratic item on specific obsessional symptom. Constructed by the research team to specifically assess the severity of the patient's obsessional symptom. This item was named "obsessional thoughts". The patient was instructed to score the extent to which he suffered from these thoughts in the past week on a Likert scale from 0 (*did not bother me at all/did not occur at all*) to 10 (*it troubled me intensely*).

The Symptom Checklist-90–Revised (SCL-90-R; Derogatis, Lipman, & Covi, 1973) is a 90-item self-report questionnaire assessing general psychological and physical functioning with good psychometric qualities (Derogatis, 1994). Items are scored on a 5-point Likert scale.

The Global Assessment of Functioning (GAF; APA, 2000) scale is a widely used clinician- or researcher rated measure of psychiatric symptom severity and functioning on a psychological, social and occupational level. The scale can be used to track clinical progress of individual patients in global terms. The overall GAF scale scores range from 0 to 100 and are divided into ten deciles of functioning.

The General Health Questionnaire-12 (GHQ-12; Goldberg, 1972; Koeter & Ormel, 1991) is a 12-item self-report questionnaire used to assess general psychological distress. Items are scored using a 4-point Likert scale. The GHQ's validity and reliability was demonstrated by Koeter and Ormel (1991), and by Vanheule and Bogaerts (2005) for the Dutch version.

Saliva stress hormone levels*.* Concentrations of cortisol (µg/dl) were measured in saliva samples by means of mass-spectrometry, following the standard practice in salivary hormone research (e.g., Kirschbaum, Bartussek, & Strasburger 1992). Cortisol is considered a biomarker of an activated stress response. It plays a key role in numerous models that link (chronic) stressors to psychiatric as well as medical disease (Miller, Chen, & Zhou, 2007).

Health care costs. Via the patient's health insurance fund all health care costs were retrieved, spanning from two years before intake until follow-up 7 months after treatment termination. Costs include medication use (i.e., psychotropic and other), medical consultations (i.e., excluding the psychotherapy discussed in this paper) and job absenteeism.

The Semi-structured Change Interview (SCI; Elliott, 1999; Elliott, Slatick, & Urman, 2001) is an in-depth qualitative outcome interview, used to assess the way the patient experienced the therapeutic process, the changes that occurred during therapy, and the processes that might have brought about these changes.

Interpersonal Functioning.

The Inventory of Interpersonal Problems-32 (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000) is a 32-item self-report questionnaire with eight subscales reflecting different interpersonal problems. Items are scored on a 5-point Likert scale. Psychometric properties of the Dutch version were positively evaluated by Vanheule, Desmet, and Rosseel (2006). Desmet et al. (2008) developed a scoring system for an anaclitic/hysterical and an introjective/obsessional IIP profile.

The Core Conflictual Relationship Theme (CCRT) Method (Luborsky & Crits-Christoph, 1998) is a qualitative, systematized and reliable measure of the central relationship patterns that pervade self-other interactions (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2000). Within the patient's narratives, two researchers selected Relationship Episodes (RE's), i.e., discrete episodes in which the patient spontaneously spoke about concrete relational exchanges, decomposed in (see Introduction): (1) 'Wishes' (W), (2) 'Responses of Other' (RO), and (3) 'Responses of Self' (RS). The most typical W's, RO's and RS's constitute the final CCRT-formulation.

Procedure

Data collection happened according to the following procedure: (1) therapy sessions were audiotaped by the therapist, and transcribed verbatim by a postgraduate research assistant; (2) after every session, the patient completed IIP-32, GHQ-12, and the idiosyncratic item in the therapy room in the presence of the therapist; (3) after every session, the therapist made a brief session report in which he summarized important dynamics at the level of symptomatology and interpersonal functioning; (4) after the first session, after every eighth session, after the last session, and at follow-up (i.e., 4 and 7 months after treatment termination, respectively), the patient completed a more extensive set of questionnaires at home (i.e., IIP-32, GHQ-12, idiosyncratic item, SCL-90, BDI-II) and provided a set of 8 saliva samples (gathered on 4 consecutive days prior to the day questionnaires were filled out; one morning and one evening sample each day); and GAF-scores were administered by a research team member (except for second follow up); (5) during first follow up, SCI was administered by a research team member, and health care cost information was retrieved.

Data analysis

Data-analysis included three steps: a quantitative and qualitative outline of evolutions in patient's symptoms (Step 1), interpersonal functioning (Step 2), and their associations, embedded within a broader description of therapy process (Step 3).

In Step 1, one member of the research team (referred to below as 'researcher 1') constructed graphs on quantitative evolutions in all outcome measures of symptoms and general well-being (see Figures 1 and 2). To assess significance of change, the ACORN Toolkit (specifically designed to help clinicians and researchers calculate change related statistics for a variety of outcome measures; Brown, Simon, Cameron, & Minami, 2015) was used to calculate Reliable Change Indices (RCI; identical to RCI formula of Jacobson and Truax, 1991, but with one-tailed 95% confidence intervals;

see Brown et al., 2015) and severity adjusted effect sizes (SAES; Brown et al., 2015). Next, two research team members (i.e., 'researchers 1 and 2') attentively listened to audiotapes and read the transcripts. Both were equally informed of relevant patient demographic information and therapy characteristics (see Hill, 2012), but researcher 2 was blind to quantitative graphs. Both researchers separately identified all events where the patient explicitly referred to his obsessional symptom, and marked symptomatic evolutions throughout therapy with respect to intensity, content or form. Through subsequent discussion on the most profound changes, consensus was reached on identification of the main 'tipping points' (i.e., specific moments in the chronicle of events that turn out to be crucial for further development; Tarrow, 2004). In case of divergence, members engaged in discussions in which they questioned each other on their ideas, so that every opinion was fully expressed and understood (see also Jackson, Chui, & Hill, 2011; Schielke, Fishman, Osatuke, & Stiles, 2009) until both members agreed on the best representation of the data (Hill, Thompson, & Williams, 1997). A concise qualitative description of symptomatic evolutions was provided by researcher 1, reviewed by a third team member (familiar with the raw narrative data), and consequently refined.

In Step 2, researcher 1 constructed similar graphs on evolutions throughout therapy in interpersonal characteristics (see Figure 3), measured by IIP-32 total scores, and dependent and autonomous IIP-32 sub-profiles (see Vanheule, Desmet, & Rosseel, 2006). Again, RCI and SAES were computed using the ACORN Toolkit (Brown et al., 2015) to assess significance of change. Next, researchers 1 and 2 conducted CCRT analyses for the first therapy sessions, the 'tipping point'-sessions selected in Step 1, and the last sessions. In a first phase, both researchers attentively re-read transcripts of the identified sessions, individually selected all RE's that were suitable for CCRT coding (i.e., RE's that contained W's, RO's and RS's), and gathered to select by consensus the 10 most informative RE's. When sessions yielded less than 10 informative RE's, additional RE's were selected from the preceding and/or following sessions. In a second phase, selected RE's were then written down in a separate document and coded using the standardized coding system (Standard Category List, Edition 2; Luborsky & Crits-Christoph, 1998, p.26). In line with Hill et al. (2011), judges distinguished between (a) RE's describing interactions with *specific people*, and with *people in general*, (b) W's, RO's and RS's occurring in *all* RE's (General, G), in *at least half* of RE's (Typical, T), and in *less than half, but at least two* RE's (Variant, V). Researchers strived towards consensus on identified RE's (phase 1) and CCRT-codes of identified RE's (phase 2). In case of divergence, researchers engaged in extensive discussions (see Step 1), and gradually refined initial ratings by integrating valuable contributions of the other until consensus codes were reached (see Hill, 2012). Judges' proportions of agreement (RE's: .88, W's: .80, RO's: .83, RS's: .80) indicated acceptable correspondence for initial ratings. Finally, researcher 1 organized consensus CCRT-codes in Tables 1 – 4, which were checked for accuracy and comprehensiveness by researcher 2.

In Step 3, researcher 1 calculated longitudinal intra-subject associations (i.e., correlations between two series of repeated measures within the same subject) between evolutions in patient's symptomatic and interpersonal level of functioning. Next, researcher 1 engaged in a 'thick description'

(Pontoretto & Grieger, 2007) of the longitudinal, clinical interplay between both levels throughout therapy, in which changes in quantitative measures were linked to the treatment narrative (Dattilio, Edwards, & Fishman, 2010) and significant therapist interventions and extra-therapeutic events were discussed. Several precautions were taken to reduce researcher 1's biases and expectations and to present a 'truer' account of the data (see Hill, 2012): prior to writing, researcher 1 orally presented provisional analyses to a third research team member (familiar with the raw narrative material) and a colleague (uninvolved in the research project, but familiar with theoretical orientation and phenomena of interest, and informed about research questions), who extensively questioned her in order to focus findings more clearly in response to research questions; during the writing process, researcher 1 continually returned to raw materials to stay close to the patient's narratives, including sufficient detail and literal quotes of the patient to validate presented findings; and the manuscript was reviewed several times by the team member and colleague described above, to identify areas in need of further attention, which were subsequently refined.

Results

Step 1: Evolutions in Symptomatic Functioning

Analysis of Outcome Data. Figure 1 shows a generally descending trend over the course of the therapy (session 1-22) on self-report measures, idiosyncratic item, and cortisol concentration, and generally increasing GAF-scores. Decreases in self-reports reached significance when assessed by means of RCI (GHQ-12: RCI = -2.82, $p < .05$; SCL-90: RCI = -6.49, $p < .05$), and large SAES were observed (GHQ-12: $d = 1.69$; SCL-90: $d = 1.59$). At follow-up, changes are maintained, except for cortisol concentrations that rise again to exceed pre-treatment levels.

Several peak values can be noted during treatment (addressed Results, Step 3, qualitative description). Scores on the idiosyncratic item peaked during sessions 2, 3, 8, 15, and 16; and largely coincide with similar peaks in GHQ-12 scores.

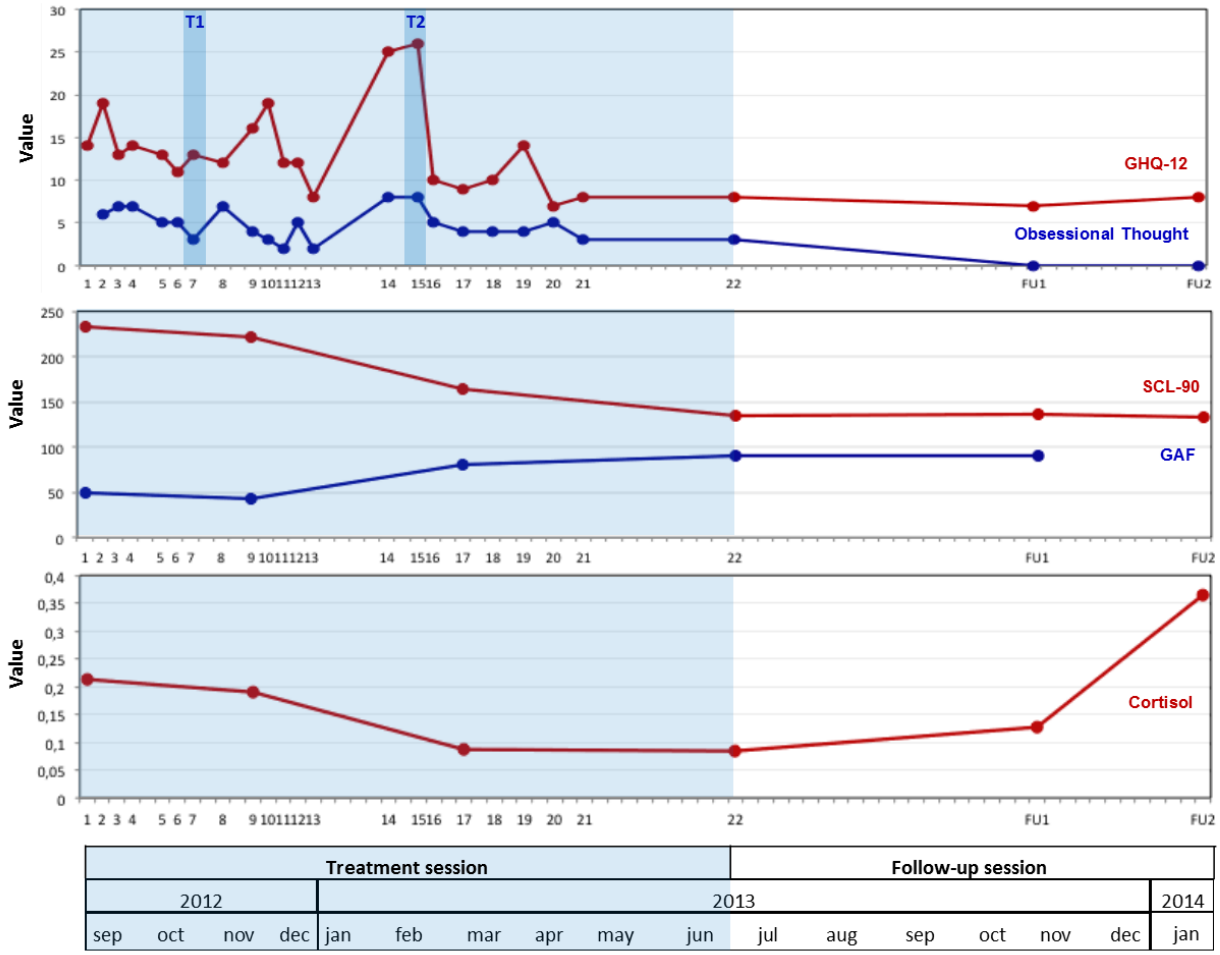

Figure 1. Evolutions in patient- and researcher-rated well-being and saliva cortisol concentrations from intake to follow-up. GHQ-12 = General Health Questionnaire-12; SCL-90 = Symptom Checklist-90-Revised; GAF = Global Assessment of Functioning; T1 = Tipping point 1; T2 = Tipping Point 2; Cortisol values: µg/dl.

The top two graphs of Figure 2 show that the patient's main health costs are due to frequent consultations of the primary care physician, six ambulant hospital admissions, and two residential hospitalizations (which were all due to medical conditions, of which one was "stress-related", i.e., stomach infection). Eight months after treatment termination, the patient started taking antidepressants again. The bottom graph of Figure 2 depicts the total sum of health costs added with two periods of job absenteeism. The first period (two weeks, May 2012) was due to bronchitis (for which his employer covered expenses). The second period spanned two months (June-July 2012, see first peak in bottom graph) just before the onset of treatment, and was due to a diagnosis (made by his primary care physician) of "depression and fear" (for which the patient received a disability allowance from his health insurance company of approximately €1000 per month). In terms of average health care costs per month, costs were highest during the treatment period. Post-treatment costs prove to be similar to expenses prior to the pre-treatment crisis in June/July 2012.

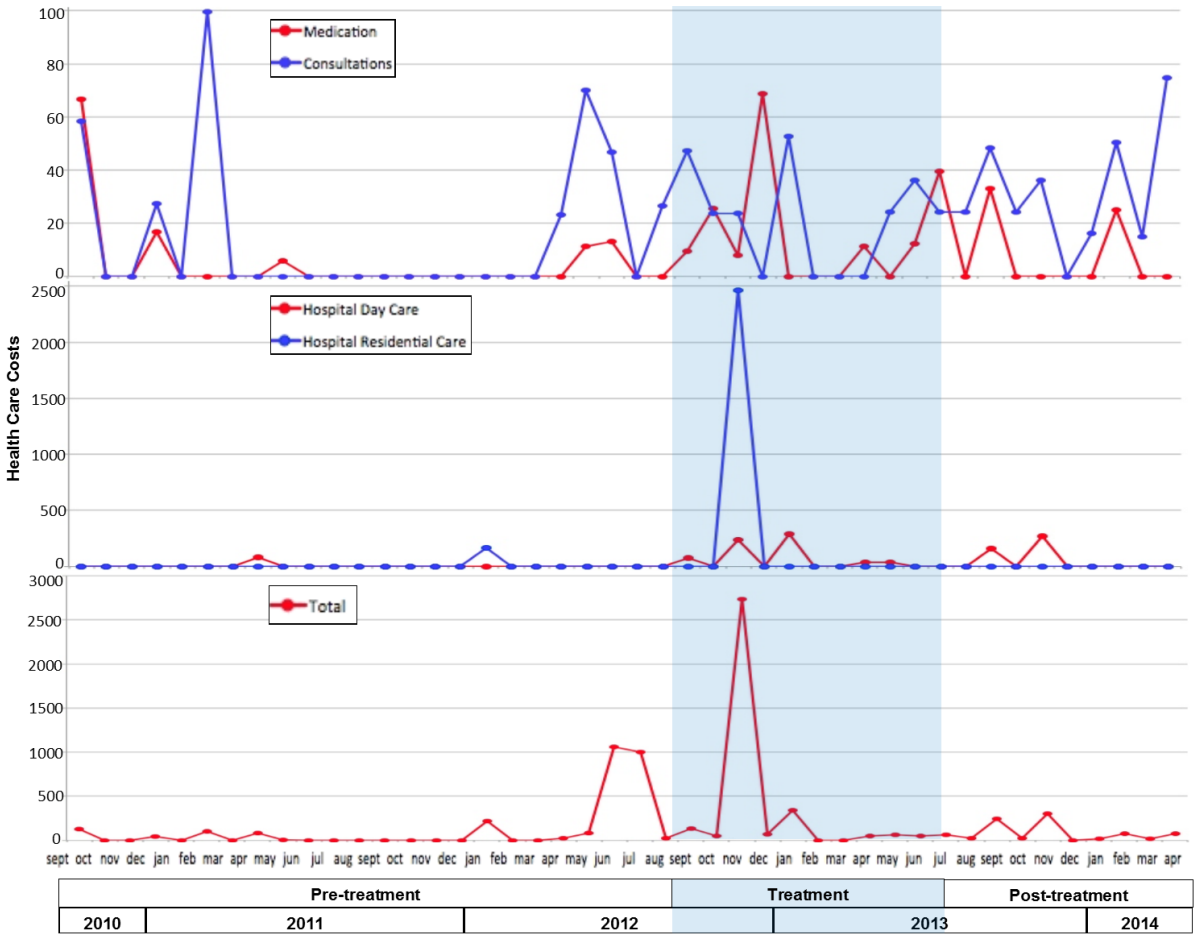

Figure 2. Evolutions in patient's health care costs (euro) from two years before onset of treatment until follow-up.

Qualitative Description of Evolutions. *Note*: Literal wordings of the patient (indicated by double quotation marks) are quoted to illustrate researchers' remarks, as natural language "more closely represents the psychological reality of human experience" (Camic, Rhodes, & Yardley, 2003).

At the onset of therapy, John's complained of obsessional "thoughts" or "images" that "suddenly jump into my mind" several times a day, and that pictured him stabbing his girlfriend Lisa with a knife. His attempts to ward off the images and to hide his intense confusion and anxiety for his surroundings, absorbed so much energy he was exhausted and irritable during most part of the day, felt depressed, and had difficulties concentrating at work (see two-month period of job absenteeism, Figure 2). In addition to alterations in symptom intensity throughout therapy (see Figure 1), several changes occurred in the content/form of the obsessional scenery: the described scene was "suddenly replaced" by intrusive images of past sexual interactions with his best friend Greg (session 7, *tipping point 1)*; by continuous "flashes" of Greg's genitals (session 9), provoking a major increase in suffering (see Figure 1); by commanding and prohibiting "thoughts" or "voices" (sessions 10-11); again by "flashes" of Greg's and male genitals (session 14); and anew by the original knife scene, accompanied by intense fears of "actually stabbing Lisa this time" and subsequent withdrawal to his parents' place (session 15, *tipping point 2*); after which "thoughts about the knife" only "occasionally popped up" and

"disappeared rather quickly" (sessions 16-22); and negative "counter thoughts" temporarily flickered again (sessions 18-19). In the last session, John declared he no longer found it necessary to continue therapy: symptom frequency and intensity had decreased significantly, it no longer inhibited him in living peacefully together with Lisa, and he felt much more energetic. During the follow-up interview, maintenance of improved symptomatic and general well-being (see Figure 1) was affirmed.

Step 2: Evolutions in Interpersonal Functioning

Analysis of Outcome Data. Similarly to Figure 1, Figure 3 shows a generally descending trend in IIP-32 scores throughout therapy and during follow-up, which reaches significance when assessed by means of the Reliable Change Index (RCI = -2.68, $p < .05$) and corresponds with a large severity adjusted effect size ($d = 1.07$). Scores for the dependent sub-profile are overall higher than for the autonomous sub-profile. Peak values are observed in sessions 4, 9, 13 (specifically for dependent sub-profile), 15 (coinciding with *tipping point* 2, Step 1) and 17; and are further addressed in the qualitative description of Step 3.

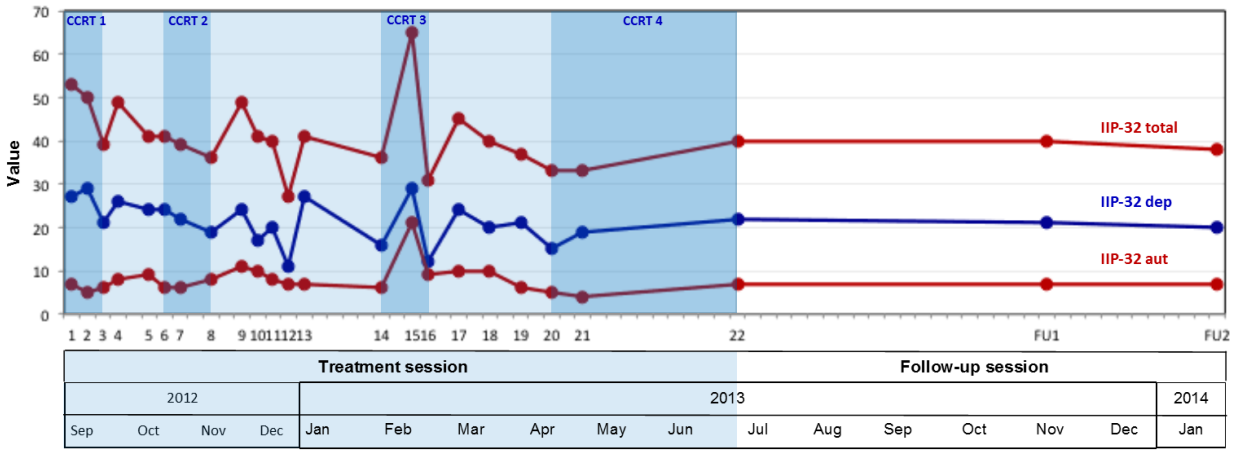

Figure 3. Evolutions in patient-reported interpersonal problems from intake to follow-up. IIP-32 total = Inventory of Interpersonal Problems-32 total scores; IIP-32 dep = Inventory of Interpersonal Problems-32 subscores dependency; IIP-32 aut = Inventory of Interpersonal Problems-32 subscores autonomy; CCRT1 = Conflictual Relationship Theme codings of first three sessions; CCRT2 = Conflictual Relationship Theme codings of Tipping point 1 sessions; CCRT3 = Conflictual Relationship Theme codings of Tipping point 2 sessions; CCRT4 = Conflictual Relationship Theme codings of last three sessions.

Analysis of CCRT-codings.

CCRT's in RE's with Specific Others.

With parents. In early sessions, John generally wished (W) to be loved and to be guided in making choices; generally experienced them (RO) as over-controlling, but attributed this overprotection to their love and best interests for him. He usually considered himself (RS) too dependent of them, but felt highly uncertain when faced with autonomous choices. Throughout therapy, John increasingly wished (W) to free himself from his parents' control; current RE's

decreased significantly, whilst past, frustrating RE's with his mother increased; and he progressively succeeded in making independent choices (RS).

With best friend Greg. In early sessions, John typically wished (W) to be independent and respected, but experienced Greg (RO) as controlling and untrustworthy, making him feel (RS) dependent, uncertain and anxious. Throughout therapy, John increasingly wished (W) to be opened up to and to be close, but typically experienced Greg (RO) as punishing and distant, arousing (RS) guilt and uncertainty, and leading to a steep decrease in RE's.

With girlfriend Lisa. In early sessions, John typically wished (W) to be loved by Lisa but felt rather disappointed (RS) due to frustrating RO's. Around *tipping point 1*, he began to voice (unexpressed) anger (RS) towards her. Throughout therapy, RE's increased, accompanied by new W's to achieve, and a greater variety of positive RO's and RS's.

CCRT's Across All Interaction Patterns. In early sessions, John typically wished (W) to be his own, self-assertive person, and to be loved; but he typically experienced others (RO) as un-respectful and controlling; provoking feelings of (RS) dependency, uncertainty, anxiety, and disappointment. Throughout therapy, John increasingly wished (W) to achieve and better himself, experienced more positive RO's of cooperation and the granting of independence (except for RE's with parents and Greg), and described RS's of self-confidence and happiness.

Table 1
Patient's wishes (W), responses of other (RO), and responses of self (RS) in first three therapy sessions

Target of interaction	#	W	RO	RS
Parents	3	Be loved (G), not be responsible (G), be helped (G)	*Negative*: Controlling (G) *Positive*: Love me (G)	*Negative*: Uncertain (G), dependent (G)
Greg	7	Be own person/independent (T), be respected (T), avoid conflicts (V), be close (V)	*Negative:* Doesn't respect me (T), controlling (T), not trustworthy (T)	*Negative:* Dependent (T), uncertain (T) anxious (T)
Lisa	4	Be loved/close (T), have stability (T), be own person (V)	*Negative:* Not understanding (V), distant (V), gives independence (V) *Positive:* Happy (V), loves me (V)	*Negative:* Disappointed (T) [not expressed], angry (V) [not expressed], depressed (V) [not expressed] *Positive:* Happy (V), loved (V)
Across all interactions	16	Be own person/independent/ assertive (T), be respected (T), be loved/close (T)	*Negative:* Doesn't respect me (T), controlling (T)	*Negative:* Dependent (T), uncertain (T) anxious (T)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Number of "Across all interactions"-exchanges equals the sum of Relationship Episodes with specific, significant others as presented in the table, added by narrated Relationship Episodes with others that did not significantly recur in patient's narratives.

Table 2
Patient's wishes (W), responses of other (RO), and responses of self (RS) in therapy sessions 6 - 8

Target of interaction	#	W	RO	RS
Greg	13	Be opened up to (T), be close (T), be own person/ independent (T), be respected (T), avoid conflicts (V)	*Negative:* Doesn't respect me (T), not trustworthy (T), punishing (T), distant (T)	*Negative:* Dependent (T), guilty (T), uncertain (T), disappointed (T)
Lisa	3	Be loved (G), be close (T), achieve (V)	*Negative:* Not respecting (V), distant (V) Positive*:* Understanding (V), respectful (V)	*Negative:* Disappointed (T) [not expressed], angry (T) [not expressed] *Positive:* Loved (V)
Across all interactions	18	Be opened up to (T), be own person/ independent (T), be respected (T)	*Negative:* Not respecting (T), not trustworthy (T), punishing/opposing/rejecting (T), distant (T)	*Negative:* Uncertain (T), dependent (T), guilty (T), disappointed (T)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Number of "Across all interactions"-exchanges equals the sum of Relationship Episodes with specific, significant others as presented in the table, added by narrated Relationship Episodes with others that did not significantly recur in patient's narratives.

Table 3
Patient's wishes (W), responses of other (RO), and responses of self (RS) in therapy sessions 13 - 15

Target of interaction	#	W	RO	RS
Mother	3	Be own person/ independent (G), feel good about self (G)	*Negative:* Doesn't respect me (G), rejecting (G), opposing (G), controlling (G)	*Negative:* Uncertain (G), anxious (G), disappointed (G)
Greg	5	Be own person/ independent (G), feel good about self (G)	*Negative:* Doesn't respect me (G), rejecting (G), punishing (T), opposing (T)	*Negative:* Dependent (T), guilty (T), uncertain (T)
Lisa	5	Be close (G), be loved/taken care of (T), be respected (V)	*Negative:* Distant (V), not respectful (V), gives (too much) independence (V) *Positive:* Respectful (V), loving (V)	*Negative:* Disappointed (V) [not expressed], angry (V) [not expressed] *Positive:* Loved (T), happy (V), self-confident (V)
Across all interactions	18	Be opened up to (T), be own person/ independent (T), be respected (T)	*Negative:* Not respecting (T), not trustworthy (T), punishing/opposing/ rejecting (T), distant (T)	*Negative:* Uncertain (T), dependent (T), guilty (T), disappointed (T)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Number of "Across all interactions"-exchanges equals the sum of Relationship Episodes with specific, significant others as presented in the table, added by narrated Relationship Episodes with others that did not significantly recur in patient's narratives.

Table 4
Patient's wishes (W), responses of other (RO), and responses of self (RS) in last three therapy sessions

Target of interaction	#	W	RO	RS
Parents	7	Feel happy/good about self (G), be my own person (G), be respected (G)	*Negative*: Oppose me (G), doesn't understand (G), controlling (G), rejecting (T)	*Negative*: Uncertain (G), anxious (G), dependent (G), angry (G), disappointed (G), comfortable (T), guilty (T) *Positive*: Independent (T)
Greg	5	Be respected (T), feel happy/good about self (V), be my own person (V)	*Negative*: Controlling (T), doesn't respect me (T) *Positive*: Helpful/cooperative (T) understanding (T)	*Negative*: Angry (T), disappointed (T) *Positive*: Independent (V), comfortable (V)
Lisa	6	Achieve/better myself (T), feel happy/good about self (T), be loved (V), be opened up to (V), be understood (V)	*Negative*: Distant (V), rejecting (V) *Positive*: Helpful/cooperative (T), understanding (T), gives independence (T)	*Negative*: Uncertain (T), angry (V) *Positive*: Open (T), self-confident (T), happy (T)
Across all interactions	20	Feel happy/good about self (T), be my own person (T), be respected/understood/ opened up to (T), achieve/better myself (T)	*Negative*: Controlling (T), oppose me (T), not understanding/ respectful (T), rejecting (T) *Positive*: Helpful/cooperative/ understanding/ respectful (T), gives independence (T)	*Negative*: Uncertain (T), anxious (T), dependent (T), angry (T), disappointed (T), guilty (T) *Positive:* Independent (T), open (T), self-confident (T), happy (T), comfortable (T)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Number of "Across all interactions"-exchanges equals the sum of Relationship Episodes with specific, significant others as presented in the table, added by narrated Relationship Episodes with others that did not significantly recur in patient's narratives.

Step 3: Associations Between Symptomatic and Interpersonal Level

Analysis of Outcome Data. Longitudinal intra-subject correlations between IIP-32- scores on the one hand, and 'Obsessional Symptom'-, GHQ-12-, SCL-90- and GAF-scores, on the other, document a positive association between the patient's interpersonal dynamics and his symptomatic and general well-being (r = .26 with Obsessional Symptom, *ns*; r = .69 with GHQ-12, p < .01; r = .87 with SCL-90, *ns*; r = -.56 with GAF, *ns*). Although observed correlations were high (medium to large effect sizes), they did not reach significance due to the small number of measuring points.

Qualitative Description of Associations. *Note*: in referral to Luborsky's (1984) manual of supportive-expressive therapy, concrete therapeutic interventions are italicized and designated as

'expressive technique' ('ET') or 'supportive technique' ('ST'), including the related page in the manual. Literal wordings of patient or therapist are indicated by double quotation marks ("…").

John entered therapy feeling greatly distressed and confused (visualized in the peaking SCL-90 and low GAF-score in Figure 1) due to obsessional ideas that had "suddenly come out of nowhere" two weeks before the onset of treatment, after "three lovely months" with Lisa, his first girlfriend ever, and which had since then daily "jumped into" his mind at various, unexpected moments during the day. *Incited by the therapist (ST, p.87)*, John described during the first therapy session that these obsessional ideas generally appeared as "images" that pictured himself in the act of stabbing Lisa with a knife. Noteworthy, as John's symptom depicted the performance of an aggressive act by himself on another person, the interpersonal factor had right from the start of treatment been present in the content of the symptom itself. *When the therapist pointed this out to John (ET, p.94)*, the latter immediately appended that he experienced his symptom to stand "between me and Lisa", "inhibiting me to fully engage in our relationship", and thereby "spoiling our happiness" (session 1); again indicating a certain function of the symptom within an interpersonal relationship.

Yet, during the initial sessions, John repeatedly passed over *the therapist's repetitive queries to provide more details (ST, p.87, p.89)* on this specific scene, by hastily adding very empathetically that he experienced the aggressive content of this scene to be in great contrast with both his complaisant nature and his tender feelings towards his girlfriend. Hence, reflecting his incapacity to recognize these "images" or "thoughts" as his own thoughts, he invariantly referred to them as "those black/bad thoughts" or most often "that knife" (e.g., "I saw that knife again", session 1), thus placing the symptomatic appearances outside his conscious self, explaining their fear-inducing and intrusive nature.

Then, denying any aggressive feelings towards his girlfriend, but *encouraged by the therapist to elaborate (ST, p.87, p.89;* session 2) on the aggression staged in the symptomatic scenery, John alluded to his best friend since childhood, Greg: "When you cite aggression, the first person I think of is Greg". *Again egged on by the therapist to expand (ST, p.87, p.89)*, John explained that, as a child, he had longed - but also dreaded - to break out of his parents' safe - but suffocating - boundaries, and had thus become attracted to Greg's audacious spirit. Spending all their free time together, Greg had generally taken the leading role in deciding what to do, and John had followed. However, over the past two years, Greg had become increasingly more dominant and possessive over John, and had even regularly persuaded him to engage in sexual activities together, to which John had each time very reluctantly consented (i.e., he masturbated Greg, but never allowed Greg to touch him). Feeling ashamed, he had always kept this a secret for others. Hence, the therapist embodied the first person he had ever (though deeply embarrassedly) confided in; an act that indicated the patient's experience of a *supportive alliance* and which immediately yielded a feeling of "great relief".

Yet, despite his resulting frustration and to his own amazement, he was reluctant to "let go of"

Greg (session 2), unaware of the motives for his submissive behavior. Having met Lisa three months before the onset of therapy, he had seen an opportunity to break free from Greg's tight grip, had engaged in a relationship (with her), and had moved in with her shortly afterwards. Since then, he had met Greg only occasionally and when he had done, the latter had always reacted distantly and dismissively, which – *as specifically asked for by the therapist (ET, p.121)* – had made John feel confused and disappointed (see also Tables 1-4).

However, not seeing "what on earth this [contextual elaboration] had to do with Lisa", John initially (sessions 1-3) kept hitting the same two questions, which also occupied him "day and night" outside of therapy: (1) "Why on earth would I want to hurt Lisa, what has she ever done to me?" and (2) "Why am I unable to let go of Greg, now I am finally free from his dominance and engaged in such a good relationship?"; while his narratives continually circled within the same rigid framework of (a) Greg as a dominant, non-respectful man towards whom he only felt frustration, (b) Lisa as a sweet girl towards whom he only felt love, and (c) himself as a complaisant, non-aggressive man.

In session 3, therefore, *the therapist interrupted John's repetitive moans* about the on-going strangeness of his symptom (also reflected in the first upsurge in GHQ-12- and 'Obsessional Thought'-scores in Figure 1) and *explicitly directed him to contextualize his remarks by asking him to illustrate the specific situations in which symptomatic flares occurred (ET, p.94, p.131)*. Next, as *the therapist indicated a possible common denominator apparent in John's recited examples (ET, p.110, p.118, p.131; ST, p.89)* (i.e. "the knives" predominantly "popped up" at those moments when Lisa unpredictably changed their plans - e.g. to do an extra shift at work or to go out with friends - leaving him "alone at the house") this immediately brought about ruptures in the above mentioned framework.

First - in reference to (a) – it opened up John's discourse to a theme that would frequently re-appear throughout the whole therapy, i.e.: he was not used to being home alone, as either his mother or Greg had always wanted him around. Elaborating on the subject in the following sessions, he gradually started to recognize that their habitual dominance over him did not solely arouse resentment (as he had stressed thus far), due to frustrated longings towards autonomy, but also made him feel familiarly safe, protected and loved. *In response to further inquiries of the therapist (ST, p.87, p.89; ET, p.131)*, he began recollecting memories of past amusing interactions with Greg, who had not always been as manipulative as during the past two years, but could also be a very enjoyable person, who had reliably guided him in his attempts to break the conservative boundaries set by his parents. While reminiscing, it began to dawn on John that the fear, uncertainty and confusion he felt lately, was induced by the recent absence of Greg's familiar bossing around, which confronted him with a void. (see also Tables 1-4).

Simultaneously - relating to (b) - John cautiously started to acknowledge some irritation towards the unpredictable, and thus, unreliable Lisa. When (sessions 4-6) *the therapist introduced a possible distinction (ET, p.110, p.114, p.121)* between this resentment and his previously uttered

(fiercer) frustration towards Greg and his mother, John steadily realized that (on the up side) Lisa, unlike the latter, did respect him in his longings for autonomy and positively stimulated him in exploring and developing his own interests and ambitions, which generated his caring feelings stressed thus far. However, as she never instructed or guided him in this process, he also believed she left him "too independent", which made him feel anxious and unloved (see Tables 1-4). John suddenly perceived that his resulting resentment was rooted precisely in those feelings. This "understanding" immediately generated a feeling of "relief", as "linking" the initially alienating feelings to this interpersonal determinant made them less frightening.

Next – relating to (c) – *as the therapist suggested that (ET, p.114, p.121; ST, p.82)* (session 3) in contrast to the (thus far sketched) portrait of "John, the complaisant man", shared by both others and himself, there did seem to lurk some aggression in him, John surprisingly started to disclose about bottled up frustrations that frequently led to "outbursts of anger" when no one was watching (e.g., hitting something in the backyard), though startled by these late frustrations. *Incited by the therapist to elaborate on this newly raised theme (ST, p.87, p.89; ET, p.114)* of aggression (sessions 4-6), John gradually started to distinguish a pattern of which he had previously been unaware, i.e. in his tendencies to never communicate any of his wishes and needs to others, nor the resulting irritation and disappointment whenever they frustrated these (unexpressed) wishes. As *the therapist further inquired after (ST, p.87, p.89; ET, p.114, p.131)* determinants for this behaviour in the light of his autonomous longings, John reminisced that on those rare occasions when he had acted against the will of either his mother or Greg (e.g., buying the car he always wanted), each time something bad had happened (e.g., a car accident), of which his mother and Greg had repeatedly reminded him in an angry, cold and punishing manner, (see Tables 1-4). Thereupon, *the therapist paraphrased that (ET, p.107, p.114, p.118; ST, p.89)*, based on these experiences, John's pursuit of personal choices and desires had progressively become linked to conflict and to others' rejection and withdrawal of love, shedding light on an apparent competition between these longings towards independence, and wishes to be cherished (see 'ambivalence' discussed in Results Step 2). Committedly enunciating that he had "never looked at it that way", John now recognized he had generally chosen a conflict-avoidant, submissive position towards others – even to the point of repeatedly consenting to sexual activities he profoundly disgusted – out of deep-seated uncertainty and fear; an (newly gained) understanding he named "very interesting, it enlightens a lot of things".

Yet, intensified focus on the theme of ambivalence during sessions incited climbing agitation levels outside therapy and entailed a first intense symptomatic shift. In session 6, preceding the first symptomatic 'tipping point' (see Results Step 1), John intensely struggled with the ambivalence "Should Greg stay or go?", feeling he had to choose between him and his girlfriend. Prompted by the experienced contrast between Lisa's stimulation and Greg's "total lack of respect for him", he ended this session with the decision to "break contact with Greg and put Lisa in first place". The following session, however, John exclaimed in panic that the obsessional images of "the knives" had disappeared, but had suddenly been "replaced" by intrusive images of past sexual activities with Greg,

which likewise “jumped into” his mind several times a day, “standing between Lisa and me”. *As the therapist took up this symptomatic shift as a point of departure for encouraging John to disclose about these gruesome memories (ET, p.94, p.97, p.114; ST, p.87, p.89)* the panic decreased during the session (reflected in low GHQ-12- and ‘Obsessional Thought’-values in Figure 1) yet, steeply rose again in session 8 (together with increased IIP-32-scores in session 9, see Figure 4), reflecting John’s frustration about his persisting inability to let go of Greg. Initially reluctant, but *egged on by the therapist to resume narration about the latter (ST, p.87, p.89; ET, p.94, p.131)* (session 8), John was positively surprised by new revelations his narratives associatively brought about, i.e.: fears (1) that spending less time with Greg would make the latter so angry he would reveal “their secret” to Lisa, thereby causing an end to their relationship (i.e., choosing Lisa would actually imply losing Lisa); and (2) that the absence of Greg’s familiar guidance entailed “doing everything all alone now”. *Incited to concretize (ST, p.87, p.89; ET, p.9, p.131)* what he meant by “everything”, John began to explore his ambitions and desires during therapy (sessions 8-9) while increasingly acting upon them between sessions**.** Synchronously, he started to feel more self-confident and happy, he no longer felt the urge so much to seek out Greg’s company (see the decrease in RE’s in Table 2), engaged in more positive interactions with Lisa, and experienced a relatively stable period in terms of symptomatic burden (mirrored in the steady decrease in ‘Obsessional Thought’-values in sessions 8-11, Figure 1).

However, in the week preceding session 10, Greg had angrily blamed John for “abandoning” him and “destroying everything”, which had immediately made John feel extremely guilty. During that week, he had been constantly bothered by highly intrusive ‘commanding’ and ‘prohibiting’ thoughts “jumping” into his mind (e.g., “you must go to Greg” and “you can’t stay with Lisa”). The intense confusion and the struggle to “push away” these thoughts resulted in a temporary increase in suffering (see rise in GHQ-12- scores, Figure 1). In response to the *therapist’s question whether these thoughts possibly resembled “voices of someone else” (ET, p.94, p.114)*, John promptly linked them to (1) Greg’s wish “to have me all for himself and Lisa gone”, a wish, he now realized, he had ‘staged’ in the initial symptomatic scenery “of the knives”; and to (2) his mother’s warning voice he “heard in his head” each time he wanted to pursue an ambition or desire, which had always and still caused intense self-doubt, hampering him to “fully engage” in excelling at work or in enjoying himself. “Like something is constantly holding me back,” he repeatedly phrased.

Following this “new, interesting link”, sessions 10-14 encompassed a more stable phase in the therapeutic process (resonated in decreasing scores for symptomatic burden and interpersonal problems, and increasing rates of general well-being, see Figures 1 and 4) in which John mainly proceeded on discussing his autonomous ambitions and encountered hindrances.

Then, at ‘tipping point’ 2 (sessions 14-15), John’s interpersonal, symptomatic and general well-being complaints climaxed (as clearly visible in Figures 1 and 4). Due to unwilling practical circumstances, there had been a longer time lapse between these and the previous sessions, in which the inability to talk about what bothered or upset him to “a neutral person bound by professional

secrecy" had resulted in a building-up of pressure (thus reflecting how *the scheduling of regular appointments, as part of the treatment structure, function as inherently supportive, p.11*). During the preceding week, "the knives" had abruptly returned in such ferocity that John had been terrified to "really" stab Lisa this time and had fled to his parents' place, resulting in "a break-through": "It was as though I suddenly woke up, and thought by myself 'What the hell am I doing? This is not what I want, this is what Greg wants. But it is my turn now!'" Resolutely, he had returned to Lisa, "the knives" had diminished instantly, though "still popping up from time to time", but in a less alienating and frightening fashion. Accordingly, during therapy John now referred to his symptom as "the obsessional thoughts" and even casually uttered "obsessions are actually quite trivial, aren't they?" Non-verbally, he became notably less agitated, talked calmer, laughed more and increasingly initiated discussions on interpersonal topics spontaneously, thus *requiring less incitation from the therapist, who mainly took on a supportive stance* (sessions 16-22*), i.e. paraphrasing and encouraging John to further elaborate on his disclosures (ST, p.87, p.88)*. As such, John started to report profound interpersonal changes: both during work and leisure activities, he increasingly wanted to achieve and to compete with other men, and he started to "notice beautiful women" ("I no longer have my eyes in my pockets"). Simultaneously, the cited 'break-through' started to steady (see decreasing and stabilizing values on all measures in Figures 1 and 4), He increasingly felt more "liberated" and energetic, and invested this fresh energy in new leisure activities (e.g., indoor snowboarding). Incited by the thrill these new experiences gave him ("It feels like everything is coming to life again", see also the rise in RS's 'happy', 'confident' and 'independent' in Tables 3 and 4), he also started to be more assertive in interacting with Greg and Lisa. He finally found the nerve to confront Greg with his fears that their secret would be leaked. Reassured to hear the latter also wanted to keep it quiet, John was finally able to "leave it all behind" him and to peacefully choose for "a grown-up relationship with Lisa", while enjoying less, but more enjoyable interactions with Greg (see Tables 3 and 4). In addition, instead of biting his tongue whenever he felt frustrated with Lisa, he progressively engaged in arguments. "I can still be angry with her, but now *without* the knife," he laughed. Based on these constructive arguments and on increasingly pleasurable interactions with *as well as* without Lisa, John gradually discovered that the ambivalence – even collision – he had always experienced between his autonomous longings and his wishes to be loved, could actually co-exist, though still not in interactions with Greg or his parents, further ensuring him in his "choice for Lisa".

Elaborating on a last symptomatic 'spasm' in session 19 (see temporary rise in GHQ-12- and 'Obsessional Thought'-scores in Figure 1) – in the form of "negative counter thoughts" during pleasurable activities – John suddenly channeled the former warnings of his mother with the recognition that he was the one who put a spoke in his own wheels. He had since long inhibited his own happiness, precisely by obeying this interiorized negative voice of his mother. During the last sessions (21-22), the negative counter-thoughts had disappeared and John mainly started to reflect upon all the changes he had gone through during the last months, *integrating them with the help of the therapist in a coherent, meaningful 'story' (ST, p.87, p.89; ET, p.94, p.114)* (which lessened their frightening load), until he longer found it necessary to continue therapy. During the follow-up interview, John ascribed his maintained therapy to "having worked through a number of conflicts in my

relationships" (e.g., the feeling he had to choose between Lisa and Greg, questions about the precise nature of his relationship with Greg, the feeling of being "caged" in this relationship with Greg, and fears of cutting himself adrift from his parental home).

General Discussion and Conclusion

The classical symptom specificity hypothesis as conceptualized by Blatt (1974, 2004) formalizes psychodynamic approaches of neurotic symptoms and associated mental suffering as grounded in typical interpersonal functioning. Starting from conceptual and methodological considerations with respect to conflicting observations from previous nomothetic research, the present paper aimed at refinement of the classical hypothesis, by examining its applicability in a longitudinal case design.

In line with expectations based on the classical symptom specificity hypothesis (Blatt, 1974, 2004), longitudinal intra-subject correlations showed a close association between the patient's symptomatic and interpersonal level of functioning. Compared to the more extensive questionnaires, the correlation between interpersonal problems and 'Obsessional Symptom'-item was relatively lowest. On the one hand, this might be due to low reliability of a one-item instrument. On the other – in contrast to the idiosyncratic item, which specifically assesses obsessional symptom intensity – both self-reports measuring symptomatic/general well-being, *as* self-reports measuring interpersonal well-being, are known to be sensitive to the subject's broader negative emotionality (see Meyer et al., 2001). The shared 'error variance' might be responsible for (artificially) larger correlations between both types of questionnaires (see also Desmet, 2007).

The clinical material (therapy transcripts) further affirmed close associations. Although at the onset of therapy, the patient could not link his symptom to any determining factors, interpersonal components proved to be already present (1) in the content/form of the symptom itself, and (2) in the patient's primal wordings concerning his symptom ("It stands *between* me and Lisa, (…) *inhibiting* me to fully *engage* in our relationship"). Also in line with expectations and consistent with findings from earlier studies (e.g., Grenyer & Luborsky, 1996; Luborsky & Crits-Christoph, 1998; Slonim, Shefler, Gvirsman, & Tishby, 2011), repeated therapeutic focus on these interpersonal associations (as supportive-expressive therapy prescribes) revealed a series of past and present contexts. The linking of recurrent incidents within these contexts led to clarifications of similarities between the patient's experiences of these events and his subsequent positioning in it. In the course of this process, remarkable changes started to take place in his formerly rigid obsessional imagery, further incited by the gaining of new, non-familiar and thus dissimilar relational exchanges with the therapist. Contextualizing these changes further led to the surfacing of new, unprocessed elements in the patient's narratives, e.g., repressed desires and ambitions, which at times also raised fears that obstructed him in the realization of these desires, and led to temporary symptomatic increases. As the patient progressively managed to link the start and evolutions in his symptom to the interpersonal

positions he occupied towards significant persons in his life, he gradually started to organize and symbolize all these determinations in a coherent story, thereby recounting the initially enigmatic experiences in a meaningful framework (see also Angus & Kagan, 2013). Hence, the symptom started to make sense again and was no longer experienced as alienating, overwhelming and frightening.

Further in line with expectations relating to the patient's interpersonal functioning, the predicted CCRT-components (Luborsky & Crits-Cristoph, 1998) as based on the classical symptom specificity hypothesis (Blatt, 1974, 2004) were observed in this patient. Consistent with findings from previous studies (e.g., Crits-Christoph & Luborsky, 1990; Vinnars, Dixon, & Barber, 2013; Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004), the patient's main CCRT's did not alter substantially throughout the therapeutic process, but higher flexibility arose in his use of different wishes and negative responses from others, as well as an increase in positive responses from others and self. According to expectations, these changes were accompanied by transformations in symptoms, as previously evidenced by e.g., Grenyer and Luborsky, 1996; Crits-Christoph and Luborsky, 1998; and Slonim, Shefler, Gvirsman, and Tishby, 2011.

In contrast, however, to the classical symptom specificity hypothesis, quantitative analysis of self-reported interpersonal problems, demonstrated it was *not* the autonomous tendency that came to the fore in this patient, but the dependent interpersonal profile, characterized by nonassertive, overly accommodating and self-sacrificing behavior; which explains the patient's initial perplexity with his aggressively laden symptom. Correspondingly, qualitative CCRT-analyses showed, in addition to the predicted autonomous components, persistent dependent W's to be loved by and close to significant others, and RS's aimed at avoiding losing their love.

Here proves the added value of triangulating data that is gathered from various (quantitative and qualitative) sources and studied from multiple perspectives within a team of researchers (Jackson, Chui, & Hill, 2011; McLeod, 2013). Complementing the context-independent, pre-fabricated quantitative measurement tools and standardized CCRT-categories, with extended qualitative analysis of narrated relationship episodes, granted the opportunity to identify factors (i.e., contextual elements and specific aspects of the patient's subjective, dynamic functioning), in which his symptomatic and interpersonal functioning proved to be intrinsically embedded. This analysis revealed that the patient's issues with dependency of others were actually rooted in frustrated, highly prominent longings towards autonomy. Dragged back and forth between two pressing wishes (i.e., to be loved and to be independent) which he, based on past interpersonal exchanges, experienced as opponent, he found himself 'stuck' in a dependent position towards others, from which he simultaneously tried to escape. Repeatedly during therapy, obsessional complaints proved to be grounded in the unbearable tension associated with this conflict. Profound *ambivalence* manifested both (1) *within* relational exchanges with his girlfriend (e.g., alternations between "she is the woman I want to be with" and "she is not a girl for me"), and with his best friend and mother (e.g., alternations between "secure" obedience and

"uncertain" revolt); (2) and in alternations *between* choosing for his girlfriend "versus" choosing for his best friend.

Conclusions and Contributions to Psychotherapy Theory, Research and Practice

At the conceptual level, the present study did not document a mere interpersonal tendency towards autonomy in this patient, but documented profound *ambivalences* between dependent and autonomous interpersonal behavior, manifested both within and between different relationships; thereby suggesting a higher complexity than originally assumed by the classical symptom specificity hypothesis. Previous studies, which used cross-sectional group designs to test symptom specificity, and thus focused on modal tendencies and static associations, did not reveal this ambivalence. In accordance with our findings, however, both classical (e.g., Freud's and Lacan's) and contemporary psychodynamic theories (e.g. Blatt's and Luborsky's) describe more complex interpersonal dynamics for patients with obsessional complaints: out of fear of losing the love of significant others, separating tendencies are usually accompanied by feelings of ambivalence (e.g., Blatt, 2004; Verhaeghe, 2001). It would be valuable for future research efforts (discussed in more detail below) to further examine this suggested complexity.

At the methodological level, we believe that single case research, in which extensive multiple method and multiple source data sets on one patient are analyzed, is necessary to grasp the complex clinical interplay between symptoms and interpersonal dynamics, and, consequently, to indicate on which points the classical symptom specificity hypothesis needs refining. Additionally, in accordance to previous research (e.g. Stiles & Shapiro, 1989; Hill, 2012, p.39; Luyten, Blatt & Mayes, 2012), the present study showed that important changes at the level of symptomatic and interpersonal functioning could best be understood as non-linear functions. As evidence-based case studies enable researchers to observe and analyze complex materials and have the additional advantage of avoiding specific types of measurement error frequently occurring in group designs (see Desmet, 2013), they are key to understanding the complexity of therapeutic change.

Importantly, the present study draws attention to the difficulty of univocally determining therapy outcome in terms of successful or not. The patient's narratives and self-report questionnaire scores showed significant improvements throughout therapy, both in the patient's symptomatology and interpersonal functioning as in his general well-being. Evolutions in these areas as described by patient and therapist, both during treatment and during follow-up assessments, are even more pronounced than depicted by the outcome measures. In accordance to findings in Randomized Controlled Trials and other large-scale studies on the efficacy of psychodynamic therapy (see recent reviews of Fonagy, 2015, and Leichsenring et al., 2015), these improvements were maintained at follow-up or even increased. However, findings were somewhat contradicted by saliva stress hormone measurements and health care cost information. In line with the positive evolution in self-report data, cortisol concentrations decreased during treatment and post-treatment costs proved similar to costs

prior to the pre-treatment crisis (June/July 2012). Yet, in contrast to self-report measures, cortisol levels went up again during follow-up and even exceeded pre-treatment levels. Further, despite affirmation of maintained improvements in symptomatic and general well-being during the follow-up interview, health costs revealed that eight months after treatment termination the patient had restarted antidepressant medication.

Hence, in applying a "multimethod, multiperspective approach on assessing outcome" (Hill, Chui, & Baumann, 2013, p.75), a more differentiated assessment of therapy progress appeared and areas were made visible that are not readily accessible through other techniques. Assessing a wider range of outcomes is viewed to be important, as (the patient's and/or therapist's and/or researchers' notion of) change does not always equal symptom reduction (e.g., Blatt & Auerbach, 2003). Scientific documentation proved to be a beneficial addition to a sole reliance on clinical judgment in assessing treatment response, as it warrants against premature clinical optimism. Independently from the clinician's perception, self-report questionnaires, saliva cortisol and/or health care information can identify areas in which improvement is limited or even absent, and which are not readily revealed to the therapist in a direct, oral fashion. Previous research (e.g., Hill, Chui, & Baumann, 2013) has pointed to possible divergences between therapists' and patients' perspectives on process and outcome in psychotherapy. Hence, carefully weighing various (divergent) pieces of evidence against each other seems advisable.

For this patient we propose the following interpretation. As explicitly stated by the patient at the end of treatment and during both follow-up assessments, he got rid of the symptoms he suffered from at the onset of treatment, and prominent changes took place in his broader (inter)subjective functioning. Once the symptoms disappeared, however, the patient stopped therapy and "fled into health" (Freud, 1978 [1905e]; Freud, 1978 [1909d]). Consequently, important aspects of subjectivity might not be worked-through (e.g., Verhaeghe, 2004) and, during the follow-up phase, new intra- and inter-subjective conflicts could have manifested, inducing distress that could have made cortisol levels rise again. Resistance might have prompted the patient to ignore these conflicts, trying to deal with the distress by taking anti-depressants again. Other interpretations are very well possible; follow-up contact with the patient could bring clarity into this findings.

Limitations and Future Research Indications

The present study aimed to address several methodological limitations intrinsic to statistical hypothesis-testing research in cross-sectional group designs in an effort to further enhance a rich understanding of symptom specificity. Accordingly, however, restrictions apply in statistical generalizability of the results to broader populations of obsessional subjects. Therefore, the applicability of the proposed refinement (i.e., ambivalent rather than autonomous interpersonal behavior) should be critically tested in larger scale studies of obsessional subjects. These studies should include (1) *cross-sectional* analyses of co-occurrences of autonomous and dependent

interpersonal tendencies within these subjects, measured both (1a) *quantitatively*, based on a variety of patient-, therapist-, and researcher-rated outcome and process measures, as (1b) *qualitatively*, with respect to the according CCRT-components, and (2) *longitudinal* investigations of their dynamic interactions with symptom alterations over time, (2a) *first* in *individual* (clinical) contexts (i.e., series of single and multiple case studies), using *quantitative* intra-subject correlations, and *qualitative* examinations of change processes (e.g., CQR-c, Grounded Theory methodology,…). (2b) *Subsequently,* it would be valuable to *aggregate* these findings over groups of subjects to make statements about group-level *patterns.* In this way, findings can be contrasted as to whether (dis)similar patterns can be found in underlying processes responsible for interpersonal and symptomatic alterations that led up to the discussed treatment outcome (see also Iwakabe & Gazzola, 2009). Finally, quantitative-qualitative examinations of change processes occurring in psychotherapies from alternative treatment schools, grant the possibility of yielding (distinctive) observations that fail to correspond to the classical theory, thereby stimulating further theory improvements (e.g., Stiles, 2015).

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3

EMPIRICAL CASE STUDY 2

INTERACTIONS BETWEEN OBSESSIONAL SYMPTOMS AND INTERPERSONAL DYNAMICS THROUGHOUT PSYCHODYNAMIC PSYCHOTHERAPY:

A SECOND CASE OF OBSESSIVE-COMPULSIVE DISORDER[11]

The classical symptom specificity hypothesis (Blatt, 1974) particularly associates obsessional symptoms to interpersonal behavior directed at autonomy and separation from others. Cross-sectional group research, however, has yielded inconsistent findings on this predicted association, and a previous empirical case study (Cornelis et al., 2016; see Chapter 2) documented obsessional pathology to be rooted in profound ambivalences between autonomous and dependent interpersonal dynamics. Therefore, in the present empirical case study, concrete operationalizations of the classical symptom specificity hypothesis are contrasted to alternative hypotheses based on the observed complexities in Chapter 2. Dynamic associations between obsessional symptoms and interpersonal functioning is further explored, aiming at further contribution to theory building (i.e., through suggestions for potential hypothesis-refinement; Stiles, 2009). Similar to the first empirical case study (Chapter 1), Consensual Qualitative Research for Case studies is used to quantitatively and qualitatively describe the longitudinal, clinical interplay between obsessional symptoms and interpersonal dynamics throughout the process of supportive-expressive psychodynamic therapy. In line with findings from Chapter 1, findings reveal close associations between obsessions and interpersonal dynamics, and therapist interventions focusing on interpersonal conflicts are documented as related to interpersonal and symptomatic alterations. Observations predominantly accord to the ambivalence-hypothesis rather than to the classical symptom specificity hypothesis. Yet, meaningful differences are observed in concrete manifestations of interpersonal ambivalences within significant relationships. Findings are again discussed in light of conceptual and methodological considerations; and limitations and future research indications are addressed.

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[11] This chapter is based on Cornelis, S., Desmet, M., Van Nieuwenhove, K., Meganck, R., Willemsen, J., Inslegers, R., & Feyaerts, J. (under review). Interactions between obsessional symptoms and interpersonal ambivalences in psychodynamic therapy: An empirical case study. *Frontiers in Psychology.*

Introduction

The centrality of interpersonal dynamics to the emergence and maintenance of symptoms has always been stressed in psychoanalytic theory. From the beginning, Freud (1978 [1915c]) situated the 'cause' of neurotic psychopathology at the level of the libidinal organization. This was theorized to determine character formation, the accompanying relational characteristics, and the phenomenology of psychopathological symptoms (Freud, 1978 [1908b]). Since Freud, a pivotal aim of psychoanalytic research has been to identify and describe specific interpersonal dimensions, and their associations with particular symptom patterns.

In this context, the symptom specificity hypothesis of Blatt (1974, pp. 155-157) discerns two major interpersonal styles, which are differentially associated with distinctive types of neurotic symptoms. On the one hand, the *autonomous* style is hypothesized to be associated with obsessive-compulsive symptoms (e.g., obsessional ideas, compulsions, pathological doubt, inhibition), which are viewed to be distorted attempts to install a sense of self-definition and separation from others. The *dependent* style, on the other, is related to bodily symptoms (e.g., conversion reactions) and phobias, seen as exaggerated attempts towards closeness to significant others.

In order for theories to be clinically useful (i.e., grant the opportunity to inform every day clinical practice) and provide coherent, precise accounts of the phenomena under study, they need to be empirically tested in research endeavors that enable to indicate areas where theories potentially need to grow (e.g., Stiles, 2009). Over the past decades, Blatt's symptom specificity hypothesis has been put to the test in several cross-sectional group studies, which failed to yield converging results (for a review, see Desmet, 2007). It has been remarked that this lack of convergence might be due to conceptual and methodological shortcomings of the studies addressing symptom specificity. Recently, Cornelis et al., (2016) raised several of these issues related to nomothetic research designs.

Conceptually, it was argued that the concrete operationalizations of the classical symptom specificity hypothesis that were tested in cited studies, possibly yielded an underestimation of the complexity of associations (see also Desmet, 2013). Importantly, Blatt's theory primarily intended to define a complex, clinical interplay between symptomatic and interpersonal characteristics over time.

Hence, *methodologically*, pertinent investigation into these dynamics requires longitudinal, clinical data, in which co-variations between both levels can be analyzed over time or throughout the course of a treatment process. However, up until now, all studies that tested symptom specificity:

- Were cross-sectional in nature (i.e., relying on measurements of symptoms and interpersonal characteristics on one single time point) and, thus, described static associations;
- Focused on modal, invariant patterns in (large) groups of participants, thereby providing rule-based, abstract knowledge in which both intra-individual variability and (potentially relevant) contextual factors were disregarded as noise;

- Applied solely quantitative, patient-reported assessment of symptoms and interpersonal characteristics (i.e., by means of self-report measures, which are known to be subject to a variety of biases; e.g., Schwarz, 1999; Desmet, 2007).

Cornelis et al. (2016) concluded, therefore, that rather than focusing on additional statistical testing of the classical symptom specificity hypothesis in nomothetic research designs, there might first be a need to refine it on some points. Empirical case research specifically allows for hypothesis-refinement and theory building (e.g., Stiles, 2009) in a clinically useful manner (e.g., Edwards, Dattilio, & Bromley, 2004). Rigorously conducted case studies bear the ability to extend de-contextualized, rule-based knowledge on established theories, by incorporating (intra- and extra-therapeutic) contextual influences into thick descriptions of naturally unfolding processes and interactions over time. It has been argued that useful clinical theories need to account for both *patterns* amongst the complexity of psychotherapeutic processes, as well as specific *variations* and the applicability of group-based findings to the *idiographic* contexts of every day clinical practice, i.e., in which dynamic and multiple factors operate in ongoing processes, and in which consumers of research prove to be particularly interested (e.g., Flyvbjerg, 2006; McLeod, 2013; Stiles, 2009).

In an effort to meet the raised shortcomings and to detect areas where potential refinement of the classical hypothesis is necessary, Cornelis et al. (2016) put forward a research methodology (discussed below) that was specifically tailored for addressing dynamic associations between symptoms and interpersonal dynamics throughout longitudinal therapy processes. The present study applies this methodology to test symptom specificity in an empirical case study of a patient with obsessional complaints. The patient was treated in a real-world clinical practice by means of supportive-expressive psychodynamic therapy (Luborsky, 1984).

Concretely, the aim of the paper is two-fold:

1. To test concrete operationalizations of the classical symptom specificity hypothesis (as presented below)
2. To thoroughly investigate the dynamic unfolding of associations between the patient's symptomatic and interpersonal functioning throughout therapy.

The additional discovery-oriented nature of the design thus scopes for the detection of distinctive, unexpected findings that could indicate where the classical hypothesis potentially needs to grow. In this way, we address recommendations of both earlier research on symptom specificity to make use of longitudinal designs (e.g., Pilkonis, 1988) in mental health clinical settings (e.g., Huprich, Rosen, & Kiss, 2013; Werbart & Forsström, 2014), as broader claims in psychotherapy research to direct future research endeavors towards the increased use of idiographic research (e.g., Barlow & Nock, 2009; Dattilio, Edwards & Fishman, 2010; Hill, 2012; Iwakabe & Gazzola, 2009; McLeod, 2013; Stiles, 2009; Vanheule, 2014).

The applied methodology (Cornelis et al., 2016) compiles a combination of Consensual Qualitative Research for Case studies (CQR-c; Jackson, Chui, & Hill, 2011), which serves as the overarching data-analytic approach, and the 'Core Conflictual Relationship Theme' method (CCRT;

Luborsky & Crits-Christoph, 1998), as a means of systematizing empirical investigation of interpersonal behavior.

CQR-c has specifically been developed to assess complex clinical material in a rich and nuanced fashion. By addressing the data through different angles in a team of researchers, a broad dialogue amongst competing perspectives is explicitly installed throughout multiple team meetings, until all team members agree on the best representation of the data (Hill, Thompson, & Williams, 1997). This 'triangulation' process is claimed to result in a more meaningful understanding of the studied phenomena (Dattilio, Edwards, & Fishman, 2010) and to significantly contribute to the 'credibility' (i.e., the qualitative parallel of validity; Morrow, 2005) of the results.

CCRT methodology, as a widely used method in psychotherapy research, is based on Luborsky's (1962) theory that subjects' relational exchanges are underpinned by a typical 'core conflict'. This conflict is comprised of three major components (Luborsky & Crits-Christoph, 1998): the wishes, needs or intentions with which a subject enters relational exchanges ('Wish', W); the subject's appraisal of how the other person responds to these wishes ('Response of Other', RO); and his/her own responses to these ROs ('Response of Self', RS).

As symptoms are theorized to be deeply rooted in the subject's core conflict, Luborsky (1962, 1984) further claimed that psychotherapeutic endeavors aiming at transforming this core conflict will bring about symptomatic changes, which has previously been evidenced by e.g., Grenyer and Luborsky (1996), Luborsky and Crits-Christoph (1998), and Slonim, Shefler, Gvirsman, and Tishby (2011). Hence, in accordance with the supportive-expressive therapy (Luborsky, 1984) under study, the applied CCRT-method provides conformity between the treatment as conducted by the therapist, and the researchers' method of analyzing the narrative data extracted from this treatment.

Next, with the aim to illuminate different aspects of (the wide spectrum of possible changes in) the studied variables (e.g., Hill, Chui, & Baumann, 2013), extensive multiple method and multiple source data sets were analyzed. Symptomatic and interpersonal functioning, and their according associations, were assessed regularly throughout treatment and follow-up, in both a quantitative and qualitative fashion, from perspectives of patient, therapist and researchers. Symptoms and associated mental distress were additionally mapped via saliva cortisol concentrations (i.e., hormonal biomarkers of distress) and health care costs (i.e., information on all mental and physical health related expenses and job absenteeism; see Method section).

Recently, this combination of CQR-c and CCRT methodology has been applied for symptom specificity research in a previous empirical case study of a patient with obsessional complaints (Cornelis et al., 2016). Importantly, this study shed light on complexities that were not captured by the classical symptom specificity hypothesis, and thus resulted in a suggested refinement. Close associations were observed

- between the patient's symptomatic and interpersonal functioning,
- between therapist interventions focusing on interpersonal conflicts and interpersonal and symptomatic transformations.

Yet, instead of the predicted predominance of *autonomous* interpersonal behavior, obsessional symptoms were observed to be rooted in profound *ambivalences* between autonomy and dependency. More specifically, recent separating attempts to break out of long-established dependent interpersonal issues, meaningfully determined the patient's obsessions. These ambivalences were observed both *within* significant relationships (i.e., in alternating loving and vindictive relational exchanges within each relationship), as *between* significant relations (i.e., alternatively preferring one relationship above the other), and thus suggested more complex interpersonal dynamics than originally assumed by the classical symptom specificity hypothesis. Yet, the suggested complexity proved in accordance with the hypothesis' broader theoretical underpinnings. Both classical (e.g., Freud, Lacan) and contemporary (e.g., Blatt, Luborsky) psychodynamic theories document separating tendencies in close association with feelings of ambivalence, i.e., out of fear of losing the love of significant others (e.g., Verhaeghe, 2001).

Aiming to contribute to a rich, nuanced understanding of symptom specificity, the present 'theory-building' case study (Stiles, 2009) will further explore clinical complexity of associations between obsessional symptoms and specific interpersonal dynamics. For that purpose, concrete operationalizations of the classical symptom specificity hypothesis (Blatt, 1974, pp. 155-157) are contrasted to alternative hypotheses based on cited findings of Cornelis et al. (2016).

Operationalizing interpersonal characteristics by means of the CCRT-method, the classical symptom specificity hypothesis leads up to the following **predictions** with respect to symptomatic-interpersonal associations in the patient under study:

H1: Before therapy (during the intake phase) we expect the obsessional symptoms to be accompanied by an autonomous interpersonal style, expressed in an exaggerated emphasis on self-definition and separation from others.

H1a: Quantitatively, we expect the patient will show an autonomous sub-profile on the Inventory of Interpersonal Problems (IIP-32), rather than a dependent sub-profile (see Desmet, Meganck & Vanheule, 2013)

H1b: Qualitatively, we expect the following CCRT-components (Luborsky & Crits-Cristoph, 1998) to underpin the patient's relational exchanges: Wishes (with which he enters exchanges) = independence, self-control, self-assertion, being acknowledged and respected, achieving; Responses of Other (i.e., his appraisal of how the other person responds to these wishes) = critical, controlling, opposing, not respectful; Responses of Self (i.e., his own subsequent responses) = anxiety, self-doubt/uncertainty, guilt, feelings of failure, (struggles with) aggression, vengeful fantasies.

H2: Throughout the therapeutic process, we expect that the supportive-expressive therapy will reduce the exaggerated strivings towards autonomy and that, as a consequence, obsessive-compulsive symptoms will diminish.

H2a: Quantitatively, we expect that scores on the IIP-autonomy profile will decrease progressively throughout therapy and that the decreasing IIP-scores will be correlated with decreasing scores on symptoms and general distress

H2b: Qualitatively, we expect that changes in the autonomous CCRT's throughout therapy (particularly in the RO- and RS- components, e.g., Crits-Christoph & Luborsky, 1990; Grenyer & Luborsky, 1996) will be accompanied by changes in the obsessive-compulsive symptoms.

Then, based on the observed complexities reported in Cornelis et al. (2016), the following **alternative predictions** are advanced:

H3: Obsessional symptoms to be rooted in *ambivalences* between a marked autonomous *and* dependent interpersonal style, expressed in profound emphasis on self-definition and separation from others, as a means of escaping interpersonal struggles with dependency.

H3a: Quantitatively, we expect the patient will report more interpersonal problems with dependency compared to autonomy, depicted in a higher dependent than autonomous sub-profile on the Inventory of Interpersonal Problems (IIP-32, see Desmet, Meganck & Vanheule, 2013).

H3b: Qualitatively, we expect, in addition to the predicted autonomous components (see *H1b*), that the patient's relational exchanges will be underpinned by persistent dependent W's to be loved by and close to significant others, RO's of rejection and distance, and RS's aimed at avoiding losing others' love.

H4: The supportive-expressive therapy will reduce the interpersonal struggles with dependency and support the strivings towards autonomy, and obsessional symptoms will subsequently diminish.

H4a: Quantitatively, we expect that scores on both IIP sub-profiles will decrease throughout therapy, and that decreasing IIP-scores will be correlated with decreasing scores on symptoms and general distress.

H4b: Qualitatively, we expect that changes in CCRT's throughout therapy (particularly in the RO- and RS- components, e.g., Cornelis et al., 2016; Crits-Christoph & Luborsky, 1990; Grenyer & Luborsky, 1996) will be accompanied by changes in the obsessional symptoms.

Method

Participants

The patient was a Caucasian man, 26-year old at the start of therapy, who was referred for treatment by his general practitioner, due to daily occurring anxiety attacks that centered on the theme of suffering or dying from heart failure. Patient was a university graduate and worked as a salesman at

a wholesale business. At intake, he met *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) criteria of Obsessive-Compulsive Disorder (axis I; no personality disorder was diagnosed on axis II). Patient provided written informed consent (approved by the University Ethics Committee) to participate in the study and to publish the individual case materials. All possibly identifying information has been changed to protect confidentiality.

The therapist was a Caucasian, 36-year old man who held a PhD in clinical psychology. Besides his job as assistant professor at the university, he worked in a private group practice. He received a three-year postgraduate training in Freudian-Lacanian psychoanalytic psychotherapy. At the start of therapy, he had six years of clinical experience.

The research team that carried out the data analyses was composed of a female assistant professor, two postdoctoral researchers (one male, one female) and two female doctoral students. All research team members were trained or following training in psychoanalytic psychotherapy from a Freudian-Lacanian orientation, were Caucasian and ranged in age between 25 and 35 years.

Therapy

In total, the patient received 23 (30- to 60-minute) sessions of supportive-expressive psychoanalytic psychotherapy (Luborsky, 1984) over 15 months, conducted in the therapist's private practice, without interference of the research team. Actual frequency of the sessions varied between once a week and once every month, with an average frequency of one session every two weeks (see Figure 1 for a time line). Step 3 of the Results section provides specific examples of supportive and expressive techniques framed within the treatment process.

Measures

Symptoms and General Well-Being.

The Symptom Checklist-90–Revised (SCL-90-R; Derogatis, Lipman, & Covi, 1973) is a 90-item self-report questionnaire assessing general psychological and physical functioning with good psychometric qualities (Derogatis, 1994). Items are scored on a 5-point Likert scale.

The Global Assessment of Functioning (GAF; APA, 2000) scale is a widely used clinician- or researcher rated measure of psychiatric symptom severity and functioning on a psychological, social and occupational level. The scale can be used to track clinical progress of individual patients in global terms. The overall GAF scale scores range from 0 to 100 and are divided into ten deciles of functioning.

The General Health Questionnaire-12 (GHQ-12; Goldberg, 1972; Koeter & Ormel, 1991) is a 12-item self-report questionnaire used to assess general psychological distress. Items are scored using a 4-point Likert scale. The GHQ's validity and reliability was demonstrated by Koeter and Ormel (1991), and by Vanheule and Bogaerts (2005) for the Dutch version.

Saliva stress hormone levels. Concentrations of cortisol (µg/dl) were measured in saliva samples by means of mass-spectrometry, following the standard practice in salivary hormone research (e.g., Kirschbaum, Bartussek, & Strasburger 1992). Cortisol is considered a biomarker of an

activated stress response. It plays a key role in numerous models that link (chronic) stressors to psychiatric as well as medical disease (Miller, Chen, & Zhou, 2007).

Health care costs were retrieved via the patient's health insurance fund, spanning from two years before intake until follow-up, i.e., 18 months after treatment termination. Costs include medication use (psychotropic and other), medical consultations (general practitioner and experts) and job absenteeism.

The semi-structured Change Interview (SCI; Elliott, 1999; Elliott, Slatick, & Urman, 2001) is an in-depth qualitative outcome interview, used to assess the way the patient experienced the therapeutic process, the changes that occurred during therapy, and the processes that might have brought about these changes.

Interpersonal Functioning.

The Inventory of Interpersonal Problems-32 (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000) is a 32-item self-report questionnaire with eight subscales reflecting different interpersonal problems. Items are scored on a 5-point Likert scale. Psychometric properties of the Dutch version were positively evaluated by Vanheule, Desmet, and Rosseel (2006). Desmet et al. (2008) developed a scoring system for an anaclitic/hysterical and an introjective/obsessional IIP profile.

The Core Conflictual Relationship Theme (CCRT) Method (Luborsky & Crits-Christoph, 1998) is a qualitative, systematized and reliable measure of the central relationship patterns that pervade self-other interactions (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2000). This method started from the narratives the patient spontaneously recounted during therapy about his relational exchanges. Within these narratives, two researchers selected Relationship Episodes (RE's), defined as relatively discrete episodes in which the patient explicitly speaks about concrete exchanges with others and/or himself. RE's are decomposed in three major components (see Introduction): (1) 'Wishes' (W), (2) 'Responses of Other' (RO), and (3) 'Responses of Self' (RS). The most typical W's, RO's and RS's constitute the final CCRT-formulation. In this paper, CCRT-coding was part of Step 2 of the data-analytic procedure described below.

Procedure

Data collection happened according to the following procedure: (1) all therapy sessions were audiotaped by the therapist, transcribed verbatim by a postgraduate research assistant and checked for accuracy by two members of the research team; (2) after every session, the patient completed the IIP-32 and GHQ-12 questionnaires in the treatment practice in the therapist's presence; (3) after every session, the therapist made a brief session report in which he summarized significant dynamics at the level of symptomatology and interpersonal functioning; (4) after the first session, after every eighth session, and at follow-up (18 months after treatment termination), the patient completed a more extensive set of questionnaires at home, including IIP-32, GHQ-12, SCL-90-R, and BDI-II; (6) at follow up, SCI was administered and health care cost information was retrieved by a research team member.

Data analysis

In order to enhance 'credibility' (Morrow, 2005) and 'trustworthiness' (e.g., Elliott, Fischer, & Rennie, 1999; Hill, 2012) of the study, the Consensual Qualitative Research for Case Studies (CQR-c) method (Jackson, Chui and Hill, 2011), was used an overarching data-analytic approach. Data-analysis happened in three main steps: a quantitative and qualitative outline of evolutions in patient's symptomatology (Step 1), in interpersonal functioning (Step 2), and in associations between symptoms and interpersonal dynamics, embedded within a broader description of the therapeutic process (Step 3).

In Step 1, one member of the research team (referred to below as 'researcher 1') constructed graphs on quantitative evolutions in all outcome measures of symptoms and general well-being (see Figures 1 and 2). To assess significance of change, Reliable Change Indices (RCI; identical to the RCI formula of Jacobson and Truax, 1991, but with one-tailed 95% confidence intervals; see Brown, Simon, Cameron, & Minami, 2015) and severity adjusted effect sizes (SAES; Brown et al., 2015) were calculated by means of the ACORN Toolkit (specifically designed to help clinicians and researchers calculate change related statistics for a variety of outcome measures, used in a variety of clinical settings; see Brown et al., 2015). Next, two research team members (i.e., 'researchers 1 and 2') familiarized themselves with the narrative data by attentively listening to audiotapes and reading the transcripts. Both members were equally informed of relevant patient demographic information and treatment characteristics (as described in 'Method' above; see also Hill, 2012), but researcher 2 was blind to the quantitative graphs. Both researchers separately identified all events where the patient explicitly referred to his obsessional symptom, and marked symptomatic evolutions throughout therapy with respect to intensity, content or form. Through subsequent discussion on the most profound symptomatic changes, consensus was reached on identification of the main 'tipping points' (i.e., specific moments in the chronicle of events that turn out to be crucial for further development; Tarrow, 2004). In case of divergence, discussions were installed in which the researchers questioned each other on their ideas, so that every opinion was fully expressed and understood (see also Jackson, Chui, & Hill, 2011; Schielke, Fishman, Osatuke, & Stiles, 2009), until both members agreed on the best representation of the data (Hill, Thompson, & Williams, 1997). Next, sessions in which the selected tipping points occurred, were visually marked on the quantitative graphs. Finally, researcher 1 provided a concise qualitative description of the discussed symptomatic evolutions (see Results, Step 1), which was reviewed by a third team member who had knowledge of the raw narrative data, and was consequently refined.

In Step 2, researcher 1 constructed similar graphs on evolutions throughout therapy in interpersonal characteristics (see Figure 3), including IIP-32 total scores, and dependent and autonomous IIP-32 sub-profiles (see Vanheule, Desmet, & Rosseel, 2006). RCI and SAES were computed using the ACORN Toolkit (Brown, Simon, Cameron, & Minami, 2015) to assess significance of change. Next, for (1) the first therapy sessions, (2) the 'tipping point'-sessions selected in Step 1, and (3) the last sessions, CCRT analyses were conducted. Researchers 1 and 2 acted as CCRT-

raters. In a first phase, both attentively read the transcripts of the identified sessions again, and individually selected all RE's that were suitable for CCRT coding (i.e., RE's that contained W's, RO's and RS's). Subsequently, judges gathered to select by consensus the 10 most informative RE's. When a ('tipping point') session yielded less than 10 informative RE's, additional RE's were selected from the session preceding and following this ('tipping point') session. In a second phase, selected RE's were written down in a separate document and coded using the standardized coding system (Standard Category List, Edition 2; Luborsky & Crits-Christoph, 1998, p.26), i.e., the one best-fitting category for each W, RO and RS is chosen from the approximately 30 categories on the standard CCRT scoring-sheet. To help ensure a richer representation of the data, and in line with Hill et al. (2011), judges distinguished between RE's describing interactions with *specific people* and RE's describing interactions with people *in general*. Further in line with Hill et al. (2011), judges distinguished between W's, RO's and RS's occurring in *all* RE's with the interacting person (General, G), in *at least half* of RE's (Typical, T), and in *less than half, but at least two* RE's (Variant, V). Judges strived towards consensus on identified RE's (Step 2, phase 1) and CCRT-codes of identified RE's (Step 2, phase 2). During consensus meetings, they alternately read aloud their individual ratings and subsequently compared them to those of the other. When agreement existed, judges proceeded to the following RE (phase 1) or CCRT-code (phase 2). In case of divergence, researchers engaged in extensive discussions as described in Step 1. Throughout this process, judges gradually refined their initial ratings by integrating valuable contributions of the other, until consensus codes were reached (see Hill, 2012). Judges' proportions of agreement (RE's: .74, W's: .71, RO's: .72, RS's: .80) indicated acceptable correspondence for initial ratings. Finally, consensus CCRT-codes were represented by researcher 1 in organized tables (see Tables 1 – 4), and checked for accuracy and comprehensiveness by researcher 2.

In Step 3, researcher 1 calculated longitudinal intra-subject associations (i.e., correlations between two series of repeated measures within the same subject, in particular the questionnaire scores obtained at regular intervals throughout therapy, see 'Procedure') between evolutions in the patient's symptomatic and interpersonal level of functioning. Next, researcher 1 engaged in a 'thick description' (Pontoretto & Grieger, 2007) of the longitudinal, clinical interplay between both levels throughout therapy, in which changes in quantitative measures were linked to the treatment narrative (Dattilio, Edwards, & Fishman, 2010) and significant therapist interventions and extra-therapeutic events were discussed. Several precautions were taken to reduce researcher 1's biases and expectations, and to present a 'truer' account of the data (see Hill, 2012): (1) prior to writing, researcher 1 orally presented her provisional analyses to a third research team member (familiar with the raw narrative material) and a colleague who was not involved in the research project (familiar with the theoretical orientation and phenomena of interest, and informed about the research questions). Both colleagues extensively questioned researcher 1 in order to focus findings and interpretations more clearly in response to the research questions; (2) during the writing process, researcher 1 continually returned to the raw material to stay close to the patient's narratives; included sufficient detail and literal quotes of the patient in the written document to validate presented findings; (3) the

manuscript was reviewed several times by the team member and colleague described above, to identify areas in need of further attention, which were subsequently refined.

Results

Step 1: Evolutions in Symptomatic Functioning

Analysis of Outcome Data. Figure 1 shows an overall increasing trend over the course of therapy (session 1 – 23) and during follow-up in both *self-reported* general psychological and physical functioning (as indicated by generally descending GHQ-12 and SCL-90 scores), and in *researcher rated* psychological, social and occupational well-being (depicted by generally increasing GAF-scores). When assessed by means of the Reliable Change Index, decreases in GHQ-12 values did not reach significance during treatment (RCI = -1.41, *ns*), but were significant when follow-up measures were included (RCI = -2.83, $p < .05$). In addition, large severity adjusted effect sizes (SAES) of changes were observed ($d = 0.85$ during treatment, $d = 1.69$ at follow-up). Decreases in SCL-90 values did not reach significance at follow-up (RCI = -1.66, *ns*) and a small severity adjusted effect size (SAES) was observed ($d = 0.41$). Noteworthy however, only three measurement points for SCL-90 could be obtained (at intake, at session 8, and at follow-up), considering that the patient lost the questionnaire set attached to session 16, and that session 24 was cancelled because of no-show. The patient's reluctant stance towards active cooperation in therapy (see Results Step 3) also manifested in his nonchalant manner of completing (i.e., fast and monotonously, mostly marking the same answers every session) and handing over the questionnaires.

Several peak values can be noted during treatment. As addressed in Step 3, GHQ-12 scores – marking general distress – peaked during sessions 2, 7, 11, 15, and 20.

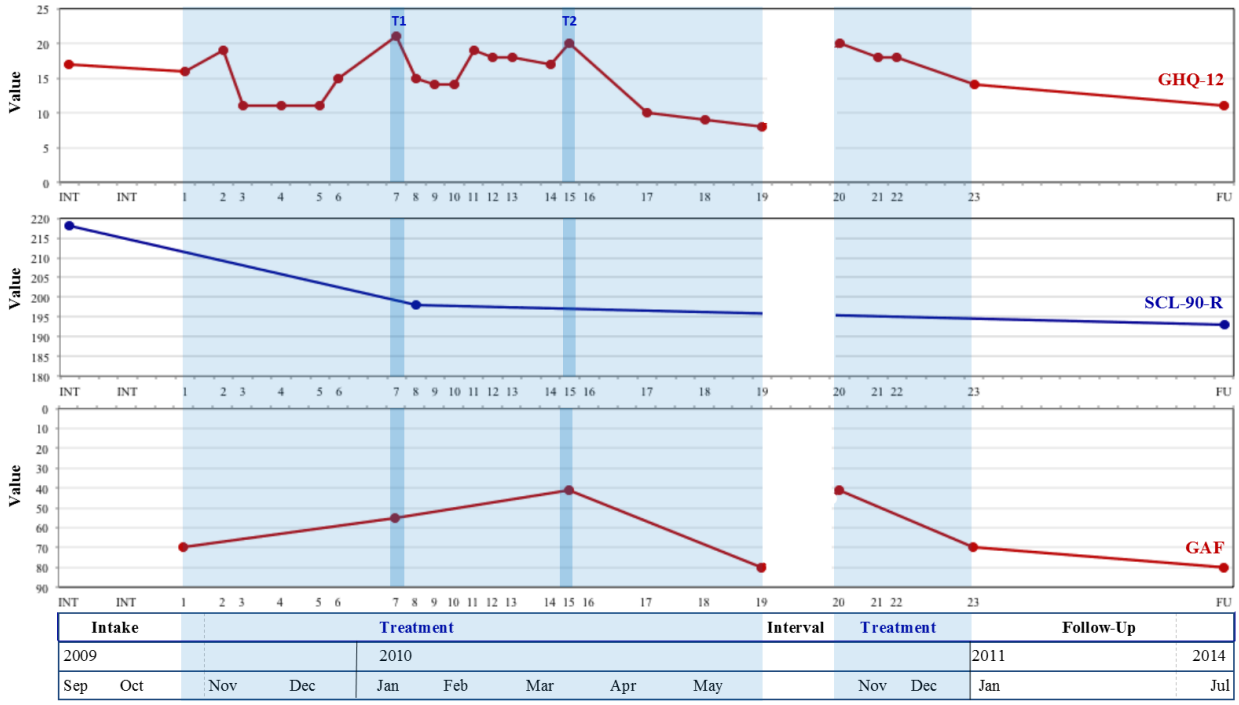

Figure 1. Evolutions in patient-reported (GHQ-12, SCL-90) and researcher-rated (GAF) well-being from intake to follow-up. GHQ-12 = General Health Questionnaire-12; SCL-90-R = Symptom Checklist-90-Revised; GAF = Global Assessment of Functioning; T1 = Tipping point 1; T2 = Tipping Point 2; Treatment was interrupted between sessions 19 and 20.

Next, Figure 2 depicts a variety of health care costs made in a period spanning from two years before the onset of treatment until follow-up. The top two graphs show that the patient's main health costs during that period went to (a) frequent consultations of his primary care physician and medical experts (especially dentists; see "Consultations" in Figure 2) – which were lowest *during* the treatment period – and (b) blood sample analyses, radiography and medical imaging (see "Blood Analyses & Medical Imaging" in Figure 2), which the patient never mentioned during the sessions. Importantly, during the observed period, no (medically prescribed) psychotropic medication was used, nor were there any periods of job absenteeism due to a physical or psychological condition. Moreover, despite the patient's intense fears of "terrible", life threatening diseases, not a single hospital admission (day/residential/emergency hospital care) was administered. Every therapy session, the patient explicitly expressed his pride about not having consulted his primary care physician and not having taken any sedatives since the onset of treatment, which he greatly contrasted to the pre-treatment period.

The bottom graph of Figure 2 depicts the total sum of health care costs. In terms of average costs per month, a slight descending trend is observed from pre- to post-treatment. Costs were highest during the pre-treatment period (average of €27 per month) compared to the treatment period (€25 per month) and post-treatment (€23 per month).

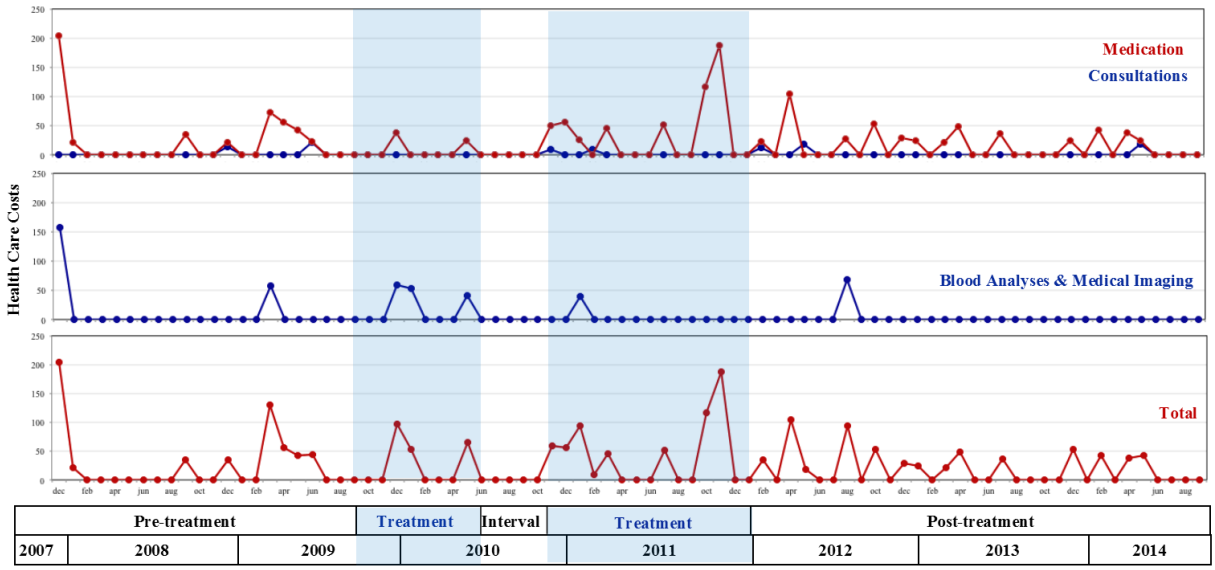

Figure 2. Evolutions in patient's health care costs (euro) from two years before onset of treatment until follow-up; Treatment was interrupted between sessions 19 and 20.

Qualitative Description of Evolutions. *Note*: As we find it important to stay close to the literal wordings of the patient in illustrating our remarks, we frequently quote citations of the patient throughout the text, indicated by double quotation marks ("..."). Italics within these quotations indicate stressing by the research team.

At the onset of treatment, Chris complained of "anxiety or panic attacks", arising from intense fears that certain bodily sensations (especially situated around the heart area) were omens of "terrible diseases" or precursors of sudden death. The self-declared "obsessive monitoring" of his own body (in the first place of "the normality" of his heart rate) consumed a lot of time and energy, caused him additional distress and intensified his "bodily symptoms". Panic attacks occurred almost daily (sometimes amounting to several a day), varied in intensity and duration (from several minutes to several hours), took place in various contexts (see Results Step 3), and inhibited him in continuing his ongoing activities. Afterwards, he regularly felt exhausted.

Following the diagnostic sessions (see 'Intake Phase' on Figure 1) – and thus "finally knowing what I suffer from" – Chris happily claimed to feel much better, and his symptoms diminished for several weeks. From the second therapy session onwards, however, "little attacks" started to rise again (see increase in GHQ-values in Figure 1) and he presented a new, "*psychological*" symptom, i.e., "being unable to speak about myself" or "bottling up". During the stable period (sessions 3 – 6) in which "the *bodily* aspect had almost disappeared", this psychological symptom became "the biggest issue". *Tipping point 1* (session 7) again yielded an upsurge in Chris' suffering (see second rise in GHQ-values, Figure 1): anxiety attacks were experienced more intense and sequenced each other more rapidly. In addition, Chris complained of intense agitation, felt tired and low-spirited, was "bottling up" again, and became very impatient concerning progress in therapy. Contrastingly, during sessions 8 – 10, he had "assumed a more acceptant attitude" towards his symptoms. This made him "feel stronger to ward off" his troublesome thoughts and fears, and "resulted in less frequent and less

intense anxiety attacks". Except for session 11, during which he complained of "very much heart problems" that occurred "without any reason", this stable period of feeling "inwardly calm, less agitated" and being "more talkative", prolonged until session 15 (see Figure 1). Yet, the stagnation in symptom frequency and intensity made Chris feel increasingly more frustrated and impatient. In session 15 *(tipping point 2)*, "bodily symptoms", anxiety attacks and profound agitation were almost continually present and interfered intensely with his ongoing activities. This provoked a depressed, apathetic mood, uncertainty, and "a feeling of incapability to handle the future". In contrast, sessions 16 – 19 again yielded increasing symptomatic and general well-being (see lowering GHQ-values, Figure 1). Chris generally felt "very good", "much stronger" and "less frightened in everyday life"; his thoughts "no longer continually lingered to hospitals and diseases"; anxiety attacks occurred only occasionally anymore and disappeared rather quickly; he talked more about himself, and looked brighter towards the future. Hence, following session 19, he interrupted therapy for five months. Upon return in session 20, panic attacks had re-appeared. Anew, he no longer felt "in control of my bad thoughts", and complained of profound distress, low spirit and tiredness. As this condition ameliorated again during sessions 21 – 22, he asked to lower the frequency of therapy sessions. During the last session, he happily announced that his bodily aches and worrisome thoughts inhibited him increasingly less in daily activities, and that he felt "much more energetic and hopeful". Although a new session appointment was scheduled, he did not return to therapy.

During the follow-up interview 3.5 years later, Chris affirmed maintenance of therapy gains: "I am feeling pretty good", "I focus less on bodily sensations" and "I have assumed the agitation" (that he still tried to ward off during the treatment period) "as part of who I am". "Good periods" continued to be interrupted by "temporary dips", during which "built-up tensions broke out physically", anxiety attacks occurred more often, and anxiety, tiredness and anger were more present. However, he had "learned to live with the anxiety attacks, and cope with them without resorting to medication".

Step 2: Evolutions in Interpersonal Functioning

Analysis of Outcome Data. Figure 3 depicts the evolutions, throughout therapy and during follow-up, in both IIP-32 total values and scores for the dependent and autonomous IIP-32 sub-profiles. Similar to Figure 1, Figure 3 shows a generally descending trend in IIP-32-scores (i.e., decrease in reported interpersonal problems) throughout therapy (session 1 – 23), which reaches significance when assessed by means of the Reliable Change Index (RCI = -2.47, $p < .05$) and which corresponds with a large severity adjusted effect size (SAES; $d = 0.99$). During follow-up, this decrease is maintained.

Overall during therapy and follow-up, scores for the dependent sub-profile are higher than for the autonomous profile.

Several peak values (i.e., increasing interpersonal problems) can be noted during treatment. As addressed in Step 3, IIP-32 scores peaked during sessions 4, 6, 9, and 16.

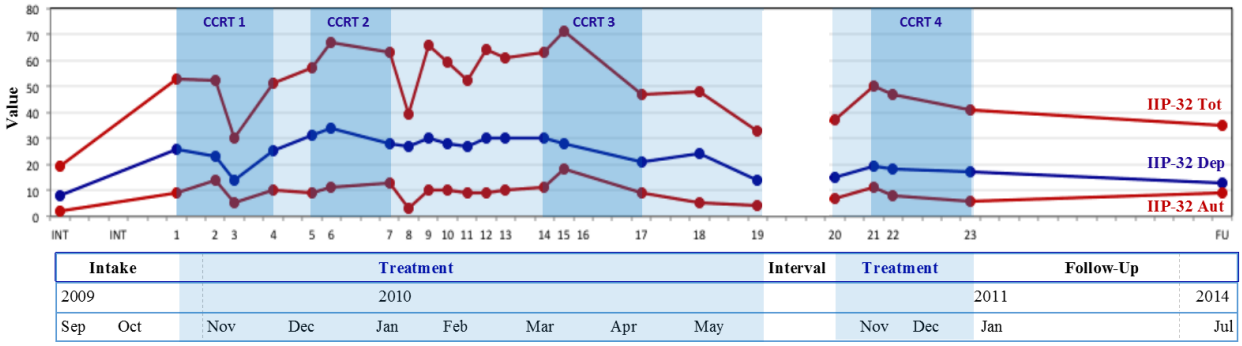

Figure 3. Evolutions in patient-reported interpersonal problems from intake to follow-up. IIP-32 total = Inventory of Interpersonal Problems-32 total scores; IIP-32 Dep = Inventory of Interpersonal Problems-32 subscores dependency; IIP-32 Aut = Inventory of Interpersonal Problems-32 subscores autonomy; CCRT1 = Conflictual Relationship Theme codings of therapy sessions 1 – 4; CCRT2 = Conflictual Relationship Theme codings of Tipping point 1 sessions; CCRT3 = Conflictual Relationship Theme codings of Tipping point 2 sessions; CCRT4 = Conflictual Relationship Theme codings of last three sessions. Treatment was interrupted between sessions 19 and 20.

Analysis of CCRT-codings. Tables 1 – 4 present CCRT-ratings of RE's with specific people and the other person in general, during the first therapy sessions (Table 1), around *tipping point 1* (Table 2), around *tipping point 2* (Table 3), and during the last therapy sessions (Table 4). Before discussing the main findings in the next paragraphs, two preliminary observations regarding the patient's interpersonal functioning are noted.

The first remark concerns the patient's characteristic manner of narrating in a very abstract manner about relations. Throughout the entire therapy, interpersonal references are scarce in the patient's discourse and are, without exception, reported as general accounts of typical, context (i.e., time and place) independent relational exchanges, which are never linked to specific (past or current) events. This is reflected in Tables 1 – 4 by the dominance of "general" W's, RO's and RS's. The patient typically speaks about the other person in terms of "they", "my fellow man" or "it" (e.g., "it was very crowded at the checkout"), without specifying concrete individuals. Specific others (even the patient's partner and his so-called "key persons", i.e., his closest friends, who are never mentioned by name) are never described in terms of character, of what attracts him in them, of what he dislikes about them, of common interests or recurring conflicts, etc. Concrete everyday examples of relational exchanges are never rendered spontaneously, and only reluctantly when asked for by the therapist. Correspondingly, Table 1 shows that narrated RE's during the first therapy sessions are limited to 6 (in stead of the required 10 for further CCRT-coding, see Method).

Second, the therapeutic relationship is not delineated separately in Tables 1 – 4 due to absence of clear CCRT-components in the enacted interactions during therapy. However, it proves significant with regard to the patient's interpersonal functioning. Overall, the therapeutic relation is markedly characterized by a hesitancy of the patient to cooperate in the therapeutic work. The patient expresses this by occasionally arriving late in sessions; forgetting questionnaires; frequently communicating his annoyance with the continuing absence of therapeutic progress and his dislike of "talking about myself"; persevering in a strict focus on his symptoms; answering very briefly and dismissively to questions; repeatedly interrupting the therapist in a loud tone; and extensively reporting the results of his daily quests for alternative ways to get better (e.g., by acupuncture, herbal

medicines, etc.).

CCRT's in RE's with Specific Others.

With Anna. Throughout the entire therapy, Chris' girlfriend Anna remained the only person with whom he felt "at ease" enough to "be myself". Whenever he faced rising anxiety levels, he immediately informed her. For him, their interactions predominantly served the purpose of reassuring him during or after anxiety attacks: "her job" was to tranquilize his fears by "rationally contradicting" the likelihood of their underlying cognitions. He generally experienced Anna as complying with these wishes, which made him feel good and safe. Yet, as she "had never experienced anxiety attacks personally", she would "never be able to truly understand" what he lived through every day, and he was "not able to explain it properly". During therapy, her demand to "talk more about myself" (i.e., "to say what I think and feel") aroused increasingly more irritation in him, and did not incite him to strive towards meeting this wish. As therapy proceeded, Chris increasingly became aware he had "never been treated with so much love" and, consequently, was "afraid to lose it again" by "doing something wrong that would make her angry and want to leave". Out of this self-declared "fear of failure", he tried to put his best foot forward towards her. Near the end of therapy, he spoke increasingly more in terms of "dependency" and "separation anxiety" in relation to her, which he was ashamed of admitting, as it collided with his ideals of being "strong" (i.e., "not needing anyone") and independent.

With parents. Throughout the entire therapy, Chris solely disclosed about past interactions with his parents, to illustrate the sharp contrast between their and Anna's stance towards him as being "the complete opposite". Whenever he had consulted his parents in the past with fears about bodily sensations, and had wanted to be empathized with and taken care of, they had "never taken him seriously", but had "always laughed off" his concerns. In addition, they had always "fixated" on his failings and had never shown any signs of genuine interest (e.g., "my father did not even know what school year I attended") or "overt love" (e.g., hugging, kissing, complementing). As a result, Chris had since long refrained from confiding anything in them.

With ex-girlfriend. Occasionally appearing in his discourse throughout therapy (see Tables 2 and 4), Chris' ex-girlfriend was (similar to his parents) contrasted to Anna as the rejecting and uninterested person who had "caused me much harm".

CCRT's in RE's With Other Person in General. During the first half of therapy (see Tables 1 and 2), most narrated RE's concern Chris' so-called "fellow man" in general, whom he never concretized or described as specific individuals. Especially in the first and last therapy sessions (see Tables 1 and 4), Chris expressed, out of a feeling of "being alone in the battle", a profound desire to find a "fellow sufferer, who understands what it is like, who lives through exactly the same as I do" (session 2); a daily quest in which he invested a considerable amount of time, but without satisfying results. Around the first and second *tipping points* (see Tables 2 and 3), Chris' "fellow man" started to appear as someone whose daily expectations – or even appearances – did not fit into his well-structured time schedule, someone with whom he had little patience, and who "agitated" him because of his/her "slowness". At the start of every day, he "pictured an image of the perfect day" and whenever something came in between (i.e., slow traffic, long rows at the supermarket, receiving a new deadline at work), he felt "annoyed" and "took revenge" by becoming irritable, "short-spoken" or

downwards aggressive (i.e., by loudly blowing the horns of his car). From session 9 onwards, others also appeared as important sources of criticism, "confronting" him with his flaws and mistakes and inducing a sense of threat, impotence and shame. Others' expected reactions of "incomprehension" (e.g., "don't clown around", "get yourself together, be a man") in response to his symptoms, were the main causes for "hiding" his anxiety attacks for "the outside world", and for adopting a "mask" or "pretense" of "the cheerful, assertive, independent man" who thrived in a "highly competitive, capitalistic job". Hence, depicted W's to be helped (which are so characteristic for RE's with Anna) merely refer to past, frustrating RE's with others, especially during his first anxiety attack in Dubai.

Table 1
Patient's wishes (W), responses of other (RO), and responses of self (RS) in sessions 1 – 4

Target of interaction	#	W	RO	RS
Anna	2	*General*: Be understood; be helped (nurtured, given support)	*General*: Understanding (empathic, sympathetic), but ultimately not understanding (about symptom); accepting; respecting; open (expressive, available); controlling	*General*: Open (about symptom), not open (about himself); accepted; respected; comfortable
Parents	2	*General*: Be understood; be helped (nurtured, given support)	*General*: Not understanding; rejecting; don't trust me (don't believe me); dislike me (not interested in me); distant; unhelpful; strict (severe)	*General*: Not open (not expressive, distant)
Other person in general	2	*General*: Be understood; be helped (nurtured, given support), be opened up to; be open (express myself) *Typical*: Achieve	*General*: Helpful, but ultimately not understanding/ unhelpful (not reassuring, not comforting); out of control (unreliable) rejecting; distant; unhelpful; strict (severe)	*General*: Don't understand (confused, poor self-understanding); uncertain; unloved (alone); anxious; open (about symptom), not open (about himself)

Note. # = Number of events; General = occurred in all events; Typical = occurred in more than half of the events; Wordings between brackets refer to 'Standard category components' within the precursory 'Standard category'.

Table 2
Patient's wishes (W), responses of other (RO), and responses of self (RS) in sessions 5 – 7

Target of interaction	#	W	RO	RS
Anna	1	*General*: Be understood; be helped (nurtured, given support); be close; help (give to); be good (do the right thing, be perfect); have control	*General*: Understanding; accepting; respecting; open (expressive, available); loves me; controlling	*General*: Open; not open; accepted; respected (valued); like her; helpful (try to please, giving); dependent; comfortable (safe, secure)
Ex-girlfriend	1	*General*: Be respected; be close to; be loved; not be hurt	*General*: Controlling; not understanding; rejecting; dislike me (not interested in me); distant; not trustworthy	*General*: Dependent; uncertain (ambivalent, conflicted); disappointed; unloved; depressed; helpful
Parents	1	*General*: Be understood; be helped (nurtured, given support)	*General*: Not understanding; rejecting; don't trust me (don't believe me); dislike me (not interested in me); distant; unhelpful; strict (severe)	*General*: Not open
Other person in general	7	*Typical*: Have control (have things my own way); be independent; hurt (get revenge) *Variant*: Be understood; be helped (nurtured, given support), be opened up to; be open (express myself); be close (not to be left alone)	*Typical*: Controlling; don't understand; angry *Variant*: Not understanding; out of control (unreliable); helpful	*Typical*: Angry (resentful, irritated); hurt others (hostile); controlling (dominating, aggressive); dependent; symptom (anxious, somatic complaints); not open *Variant*: Anxious; unloved (alone)

Note. # = Number of events; General = occurred in all events; Typical = occurred in more than half of the events; Variant = occurred in at least 2 events; Wordings between brackets refer to 'Standard category components' within the precursory 'Standard category'.

Table 3
Patient's wishes (W), responses of other (RO), and responses of self (RS) in sessions 14 – 17

Target of interaction	#	W	RO	RS
Anna	5	*Typical*: Be understood; be helped (nurtured, given support); be close	*Typical*: Controlling; angry (irritable); loves me; understanding; accepting; respecting; open	*Typical*: Not open; angry (irritated; resentful); anxious; dependent ; comfortable (safe, secure); loved
Parents	2	*General*: Be understood; be helped (nurtured, given support)	*General*: Not understanding; rejecting; don't trust me (don't believe me); distant; unhelpful; strict (severe)	*General*: Uncertain; anxious; distant; disappointed
Other person in general	3	*General*: Have control (have things my own way); be independent; feel good about myself (be self-confident)	*Typical*: Don't trust me (don't believe me); not understanding; not respectful; rejecting	*General*: Distant; not open *Typical*: Ashamed

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); Wordings between brackets refer to 'Standard category components' within the precursory 'Standard category'.

Table 4
Patient's wishes (W), responses of other (RO), and responses of self (RS) in sessions 21 – 23

Target of interaction	#	W	RO	RS
Anna	4	*General*: Be understood; be helped (nurtured, given support); be close; help; achieve; better myself	*General*: Loves me; understanding; accepting; respectful; open	*General*: Comfortable (safe, secure); loved; open *Typical*: Anxious
Parents	5	*General*: Be understood; be helped (nurtured, given support); be close (not left alone)	*General*: Not understanding; rejecting; don't trust me (don't believe me); distant; unhelpful; strict (severe) *Variant*: Dislike me (not interested in me)	*General*: Uncertain; anxious; distant; disappointed
Ex-girlfriend	2	*General*: Be respected; be close to; be loved	*General*: Controlling; not understanding; rejecting; distant; not trustworthy	*General*: Disappointed; unloved; depressed; angry (resentful)
Other person in general	6	*Typical*: Be understood; be helped (nurtured, given support); be close (not left alone); be respected; achieve; compete *Variant*: Assert myself	*Typical*: Not understanding; rejecting	*Typical*: Distant; not open; ashamed; hurt others (hostile); self-confident *Variant*: Unloved (alone); disappointed; angry

Note. # = Number of events; General = occurred in all events; Typical = occurred in more than half of the events; Variant = occurred in at least 2 events; Wordings between brackets refer to 'Standard category components' within the precursory 'Standard category'.

Step 3: Associations Between Symptomatic and Interpersonal Level

Analysis of Outcome Data. In line with expectations, longitudinal intra-subject correlations between IIP-32 scores and GHQ-12 scores document a positive association between the patient's interpersonal and symptomatic functioning throughout therapy (r = .35, *ns*). However, the observed correlation did not reach significance. Due to the small number of measuring points, longitudinal intra-subject correlations between IIP-32 scores, on the one hand, and SCL-90-R and GAF scores, on the other, were not calculated.

Qualitative Description of Associations. In this part, we contextualize the outlined symptomatic and interpersonal changes (see Step 1 and 2) in descriptions of the dynamics of the treatment process, specifically focussing on the interactions between both. The influential impact of both therapeutic and extra-therapeutic factors or events is discussed. With respect to therapist interventions, we specifically refer to the conducted manual of supportive-expressive psychodynamic treatment (Luborsky, 1984) by italicizing concrete interventions, followed by their designation as 'expressive technique' ('ET') or 'supportive technique' ('ST') and the related page in the manual. Literal wordings of the patient are indicated by double quotation marks ("…").

Chris entered therapy with complaints of daily occurring “anxiety attacks” or “panic attacks” that had abruptly started four months prior to the onset of treatment. The first, most intense one, had “suddenly” and “without any reason” occurred “while being alone” on a business trip in Dubai, whereas countless previous business trips had always come about successfully. Back home, however, a “quiet”, symptom-free period of two months had succeeded, before a second, equally unexpected, attack had occurred, this time in the presence of his girlfriend Anna. Since then, anxiety attacks had “overtook” him on a daily basis, in fluctuating intensities and durations, and in a variety of contexts, between which he dispiritedly discerned “no link whatsoever”. Hence, as the attacks “could strike me anytime, anywhere”, he continuously experienced “anticipatory anxiety” and felt intensely “uncertain”. In marked contrast with “the assertive and strong man I was before”, they divided his subjective experience in “before” and “after” the start of the attacks. Ashamed, he scrupulously hid the attacks for “the outside world”, secluding himself from the surrounding people whenever he felt them emerge”.

The recurrence in anxiety attacks had prompted him to consult his general practitioner, who had subsequently referred him to psychotherapeutic treatment. However, initially reluctant to acknowledge that “something psychologically could be involved” or that “talking would somehow help”, he had waited a month to consult the therapist, finally incited by Anna, who was convinced his attacks resulted from his “non-talkativeness”, i.e., “bottling up my feelings and thoughts” (session 2). *Encouraged by the therapist to elaborate on this subject (ST, p.87, p.89*; *ET, p.94*; session 2), Chris indifferently shrugged off Anna’s comment by saying “I am simply unable to talk about myself; I dislike it and I have never learned it at home, we never shared feelings, thoughts or opinions with one another”.

Accordingly, during initial therapy sessions, Chris’s speech was marked by continuous recitals of perplexing symptomatic appearances, often merely listing up the frequency and intensity of attacks over the past week, without any additional context (i.e., unrelated to any preceding or subsequent incidents/emotions/thoughts/reactions/interactions). *In response, the therapist repeatedly incited Chris to illustrate his remarks with concrete examples (ST, p.87, p.89; ET, p.94; sessions 1-3)*, to which Chris initially was profoundly reluctant, muttering he did not understand why the therapist had to “drag all these things into” therapeutic discussion. In addition, with each provided example, Chris firmly stressed that the “bodily sensations” he felt were “real” (i.e., “not imagined”), but that subsequent, “psychological” fears and thoughts (i.e., of suffering from “acute heart failure” resulting in his “sudden death”) made him “exaggerate” these sensations. This initiated a “vicious circle” of mounting anxiety “from which there was no escape”. In this context, he had experienced his general practitioner’s referral to “a psychologist” as deeply insulting, feeling he had “not been taken seriously”. Hence, his therapy aim was to acquire effective strategies to deal with these exaggerating thoughts, in order to limit the anxiety attacks. In the meantime, however, he remained convinced that “the only thing that could possibly help me” was “to talk to a fellow sufferer”, i.e., someone “who goes through exactly the same as I do, for only this person would be able to truly understand me” (session 2). Accordingly, he daily consumed hours of time on Internet forums in pursuit of such a person, scanning the experiences

and coping tips shared by other anxiety sufferers. Yet, as Chris experienced each of these persons to differ in one way or another from himself, he did not readily find his counterpart.

As the therapist drew attention to (ET, p.121; session 2) the great importance John attached to "being understood" and "being taken seriously" by others, Chris immediately appended that "the absolute worst thing" about his first panic attack abroad was that "nobody spoke my mother tongue". In fact, at the height of his attack, he "had almost sent a text message to Anna". Promptly, *the therapist linked this pronunciation with previous phrasings (ET, p.94, p.118, p.131; ST, p.89*; session 2) concerning his symptom, in which Anna's involvement was also apparent (e.g., "Anna and me call them 'my little attacks'", "me and Anna are reading up on obsessions", session 1) and consequently *pointed to the marked contrast (ET, p.110, p.118; ST, p.89*; session 2) between this "appeal" and his inclination to hide the attacks from everyone else. Chris added in assent that he "reported" each attack to her (i.e., on the phone or when arriving home after work), because "her job is to reassure me" by "logically remonstrating each of my cognitions and clearly showing me why it is highly unlikely that I suffer from a terrible disease or heart failure". He clarified that he recognized the "absurdity" of his fears, seeing his young age (i.e., 26 years) and a complete absence of familial predisposition for heart disease, and continued laughing that his habitual smoking behavior and unconcern for exercise or healthy food collided markedly with the described fears. However, during an anxiety attack, he was always "completely convinced" of "their verity". *When further asked to expound (ST, p.87, p.89; ET, p.94,* session 2) on his tendency of addressing Anna with his symptom, Chris emphasized that the attacks were "the only thing I cannot properly explain to her" and "the only thing that do not fit into the otherwise perfect relationship". "And the timing is not right," he added, "I really do not understand why the attacks started nòw. Now that I am finally at èàse, and for the first time engaged in a gòòd relationship, thìs comes along. It is as though all the misery of the past 20 years has all of a sudden burst out now". *At the therapist's incitement (ST, p.87, p.89; ET, p.94,* session 2), Chris clarified the sharp contrast between his current relationship with Anna, on the one hand, and past relations with his parents and ex-girlfriend, on the other, as being "the complete opposite", a theme that was frequently resumed throughout the following sessions. Whereas the latter had "always fixated on my weaknesses", "dismissed my accomplices as common or normal" and had never shown any genuine interest in him (e.g., "my father did not even know what school year I attended"), "Anna pointed out what I am good at" and did prompt him to share his thoughts, feelings and opinions with her. Yet, he experienced this "demand" as "annoying", and habitually passed it over with the pretext of "I don't know what to say", "I simply don't know how", "What does it matter what I think at the moment?" or "It is too tiresome to try and put it into words". For he stubbornly contradicted Anna (and the therapist) that his anxiety attacks could be connected to this "non-talkativeness".

However, as the initial acuteness of his symptoms diminished (see stable GHQ-12 and SCL-90 scores in Figure 1), Chris gradually became more receptive to *the therapist's interruptions of his persistent recitals of symptomatic appearances, to expound more on interpersonal references present in the provided examples (ET, p.94, p.131)*. During sessions 3-5, his non-talkativeness became a

more prominent theme of discussion (see increasing IIP-32 scores in Figure 3) and from session 5 onwards, Chris started to name the "biological" and "psychological aspect" in one breath, e.g., "I'm feeling better and I am also talking more about myself to Anna", "Maybe I used to talk too little about my feelings, corked them up too much, and that is why all the stress condensed on my body".

Together with this gradually increasing focus on (inter)personal issues, for the first time since the start of therapy Chris' "fellow being" (i.e., the other in general, see Results Step 2) appeared in his speech. He started session 5 declaring: "Now it is particularly when I am feeling agitated, that I suffer from anxiety attacks. And (laughing) I am very easily agitated". *Encouraged by the therapist to illustrate this diffusely termed "agitation" (ST, p.87, p.89*, session 5), Chris provided miscellaneous examples, *from which the therapist deduced (ET, p.98, p.118)* they all had something to do with "being impatient" and suddenly "wanting to get away" from places (i.e., traffic, his office, the supermarket), but being hampered in this by others. *As the therapist further underlined the contrast (ET, p.110, p.118; ST, p.89*) between this impatience to get away from others and his previously demonstrated appeal to Anna, Chris expanded on his wish to be close to her. He disclosed he "had never experienced so much love in his life" and that he was "utterly afraid to lose it again" by "doing something wrong that would upset her and make her want to leave" (see also Chris' elevated score on the IIP-32 subscale 'Intrusive', reflecting his fear to be alone, i.e., without Anna). This engendered a newly acknowledged discrimination between two 'types' of fear he had previously assembled together: on the one hand, his fear of not being able to please Anna sufficiently; on the other, the fear induced by unwelcome intrusions of all others in his well-organized time schedules. The intense sore throat, with which Chris entered session 6, further brought the subject round to time schedules, obligations and duties. Loudly complaining about the upcoming wedding celebrations of a close friend which he "hàd to attend, I have no other choice", Chris articulated in one breath: "I am afraid of being seriously ill ànd of not doing what is expected of me". *Asked to expound on this "time schedule" (ST, p.87, p.89)*, Chris disclosed about his habit to start the day off envisioning "an image of the perfect day", in which he always wanted "to have the final decision" ("It is all about control, I want to have control"; see also his elevated score on the IIP-32 subscale 'Domineering'). Whenever something unforeseen occurred (which inevitably happened multiple times a day, e.g., slow traffic, crowded super market, additional work deadline), he always felt his temper rise. *As the therapist tied this up with previous disclosures about "not expressing, but bottling up his feelings" (ET, p.94, p.110, p.118, p.131; ST, p.89)* and further inquired about the precise contents of the latter, it began to dawn on Chris that his corked up frustration not only caused him to "explode at some point" (i.e., reacting coldly or aggressively to others), but also incited him to contract his muscles, which eventually provoked pain, i.e., the "real, not imagined" pain he so strongly emphasized since the referral of his general practitioner. For the first time during treatment, he explicitly praised the value of focusing therapeutic discussion on contextual elements, beyond the strict symptom: "At first I was very skeptical of your way of working, I often thought 'What does that have to do with anything?' but now I can see the point of it".

Moreover, *intensifying therapeutic focus* (*ET, p.94, p.110, p.118;* sessions 5 – 8) on others'

intrusive obligations as colliding with his preferred timetable, during sessions, further incited climbing agitation levels outside of therapy (see temporary increase in reported autonomy problems in Figure 3, and simultaneous decrease in dependency issues [IIP-32-dep]), and accumulated in peak scores in general and symptomatic ill-being in session 7, *tipping point 1* (see Figure 1). *Time after time incited by the therapist to talk this agitation through (ST, p.87, p.89)* during sessions 8 – 10, while discriminating it from the love and ease he felt with Anna, Chris' peak scores dropped again (see Figures 1 and 3) and he reported to "feel much calmer". However, in sessions 10 – 11, transferential impatience started to mingle with therapeutic progress: Chris reverted to repetitive reports of symptomatic flares – that rose anew in session 11 with "an awful lot of heart problems" (see Figure 1) – while complaining again about the monotony of the sessions, which crept unwelcomly into his tight schedule. Yet, *the therapist insistently cut across Chris' repetitive discourse, by paraphrasing (ET, p.94, p.114, p.118; ST, p.89)* Chris' previous remarks about "being impatient to get awày fròm" into the inquiry whether his first anxiety attack abroad had possibly been preceded by "an impatience or eagerness to get bàck tò Anna". In response, Chris elaborately opened up about "that first time in Dubai", adding new elements to his previous fragmented narratives that shed new light on the start of his symptom. This business trip had been the first one right after he had moved in with Anna. Opposed to all previous trips, he had – for the first time ever, as he used to be a perfervid traveller – dreaded "leaving her and going away from home". *In reply to the therapist's prudent suggestion (ET, p.94, p.98, p.114, ST, p.89)* that (the creation of) his symptom had thus granted him with an excuse to return home earlier, Chris shamefully admitted "This is the first time I prefer being home above anywhere else, whereas I have always been so eager to leave". "The farther she is, the worst I'm feeling". Although he initially framed this experience negatively as "being overly dependent" and "maybe it is not healthy" (reflected in the overall higher IIP-32 dependent profile, compared to the autonomous profile, in Figure 2), he declared in session 12 to "feel much calmer" again, and "it was an interesting session last time". Synchronously, he pushed forward a new therapeutic endeavor: "It is all about learning to analyze my feelings, is it not, which I have apparently never done before, learning to cope with frustration and sorrow and uncertainties", and anew showed a greater willingness to answer therapeutic questions about issues beyond the mere symptom. Consequently, in reply to a question concerning the renovation plans that kept him busy in session 12, Chris uncovered a new element relating to the start and the following persistent recurrences of his symptom. Whilst moving in with Anna (one week before his business trip in Dubai), in the former house of her parents, in which many objects still evoked memories of the latter, he had found out Anna's father had very unexpectedly died at the age of 27 (i.e., one year older than he currently was) of a heart attack. Like in his own family, there had been no familial predisposition for heart disease and "he had optimal cholesterol values". *As the therapist's referred to (ET, p.94, p.118; ST, p.89)* previous remarks concerning Anna's job of reassuring him "that nothing is going to happen", Chris added in assent: "And that is exactly why Anna can never guarantee that nothing is going to happen: the proof is her father!"

Next, following a relatively stable period (session 13 – 14, see also Figures 1 and 3) in which the same themes were further worked through, a profound extra-therapeutic event preceding session

15 (*tipping point 2*) abruptly urged for a turn in Chris' current way of addressing Anna via his symptom. Anna had assured Chris she "was fed up" with him needing help all the time. "Even when she is not feeling too well herself, she still has to take care of me; she should also have the right to have a bad day". Utterly afraid of "ruining precisely what you, above all, certainly do not want to be ruined" (session 15), anxiety levels (see Figure 1) and reported interpersonal troubles (see Figure 3) temporarily rose again.

Remarkably, from session 16 – 19, Chris started to report important transformations, both symptomatically and (inter)personally (see decreasing trend in Figures 1 and 3). He described to be "less focused on my body" because "I know perfectly well it is not true [NB: what he fears is going to happen]", as a result of which anxiety attacks occurred less intense and less frequent. He had managed to peacefully go on a short business trip "without any problems" (session 17). As Anna had "broken through the wall I had built around me" Chris increasingly "involved her in important decisions" instead of "deciding everything on my own, like I had always done" and stopped time-consuming pursuits of "a fellow sufferer". *Upon the therapist's appraisal of this therapeutic gain (ST, p.86;* session 16), Chris low-spiritedly added that the "encounter of so much love" had also woken him up to the fact that "I am not the strongest person in the world anymore". "That is the price we pay to let someone into our lives". Next, *as the therapist took up Chris' phrasings (ET, p.94;* session 17) of Anna being "the only one with whom I can be myself and drop the pretense", Chris continued he hid his symptom out of "shame" and "the fear of being accused of play-acting and seeking attention". *Upon the therapist's inquiry after his parents' reactions when he had been ill as a child (ET, p.110, p.118; ST, p.*89) Chris reminisced they had always coldly brushed aside his wailings (i.e., "no yammering, do not look at the spot where it hurts and it will blow over"), and "never took me seriously". *When the therapist linked this latter phrasing to Chris' indignation about his GP's referral to psychotherapy (ET, p.94, p.118, p.131; ST, p.*89), Chris particularly recalled a vivid memory of their disbelieving reactions to "what they thought was just a regular cold, but which eventually turned out to be a terrible pneumonia for which I had to be hospitalized". Markedly, *as the therapist's further inquired after Chris' habitual reactions to his parents' disregarding behavior (ET, p.110, p.118*), he described how he had become hyper alert for bodily signals, "always dreading there was something wrong with me". *Again egged on by the therapist to elaborate on these themes (ST, p.87, p.89; ET, p.*94) throughout the following sessions, Chris started to realize "that this is the reason why I tend to act aggressively towards others, as a way of immediately asserting myself and showing I am not to be crossed with, that I am to been taken seriously". For he usually anticipated critique and rejection of others, but "I do not know how to react. I'm thinking a lot, but I do not say anything".

Having thus far progressed in therapy to permitting himself not to be as "strong" as he "used to be" or as he wished to display to the outside world, but to be "dependent of someone", and ask for and accept Anna's care, Chris' symptomatic, general and interpersonal wellbeing steadily increased over sessions 16 – 19. He and Anna heartily made plans to start a family, and Chris stopped attending therapy after the 19th session. A 20th session had been scheduled, but Chris failed to show up.

However, 6 months later, a second extra-therapeutic event triggered a new destabilization in Chris' life that again urged for a change in interpersonal stance, inciting him to consult the therapist anew. The imminent birth of his first child with Anna urged to confine his recently admitted dependency to a certain extent, in order to "be able to provide care myself". As he yearned "to be strong enough again" so that "Anna will not have to take care of three all by herself", he wished to attend therapy "preventively". For he feared anxiety attacks would start rising again as long as he had not learned to "cope with uncertainty and anxiety and feelings all together" but still tended to express them "in a physical way". Moreover, reminiscent of the abrupt death of Anna's father when she had still been a toddler, he added: "Now I will be the father and I'm terrified something will happen to me". *As the therapist asked for Chris' interpretation of 'being a father' (ST, p.87, p.89)*, Chris immediately emphasized he and Anna certainly did not want to raise their child like his parents had done, but "in a much more physical way" (i.e., with more loving physical contact, e.g., hugging, kissing, etc.) and "more open-faced, less coldly". In the following sessions (21 – 23), *the therapist mainly took on a supportive, incentive stance (ST, p.87)* while Chris mainly resumed illustrations of his parents' and ex-girlfriend's rejecting behaviors, in opposition to Anna's stance towards him, and his own desired stance towards his future child. Notably, he talked these themes through in a much more elaborate and calm, reflective way (see decreasing ill-being scores in Figures 1 and 3). More fiercely, he reminisced past encounters with a group of friends who had "exploited" his generosity and "did not return it" when he had needed their friendly support. At the end of session 23, he concluded: "I have grown from a general 'people pleaser' to a hot-tempered person who is very talented in his capitalistic job" and "who prefers to spend time with his family", for they are "the only ones who deserve it". *When the therapist finished the session "with this admirable character sketch" (ST, p.86, p.89)*, a new appointment was scheduled, but Chris did not return to therapy.

General Discussion and Conclusion

The present study started from symptom specificity as a fundamental concept in psychodynamic theory. In this context, Blatt's classical symptom specificity hypothesis (1974, 2004) describes differential associations between specific types of neurotic symptoms and specific styles of interpersonal functioning. Earlier nomothetic research into these associations, however, yielded mixed results, which have been argued to be due to several methodological and conceptual limitations inherent to cross-sectional group designs (see Cornelis et al., 2016). In an effort to enhance a richer understanding of symptom specificity and to detect areas where potential *refinement* of Blatt's hypothesis proved necessary, the present empirical case study aimed to contribute to *theory building* (Stiles, 2009) in a clinically meaningful way (e.g., Edwards, Dattilio, & Bromley, 2004). A specific combination of Consensual Qualitative Research for Case studies (CQR-c; Jackson, Chui, & Hill, 2011), and the 'Core Conflictual Relationship Theme' method (CCRT; Luborsky & Crits-Christoph, 1998) was applied to investigate dynamic associations between a patient's obsessional symptoms and

interpersonal characteristics throughout a longitudinal therapy process. This research method has previously been developed and applied in a similar theory-building, empirical case study of a patient with obsessions (see Cornelis et al., 2016). In the current paper, concrete predictions based on the *classical symptom specificity hypothesis* were contrasted to *alternative predictions* based on the findings of this previous study.

In line with expectations based on the classical symptom specificity hypothesis, the longitudinal intra-subject correlation affirmed a positive association between the patient's symptomatic and interpersonal functioning throughout therapy. Although the correlation did not reach statistical significance, extended qualitative analyses of the narrative material affirmed *close associations*. Despite the patient's initial reluctance to expand on the specific contexts in which his symptoms occurred, interpersonal components proved to be present in the cited examples, asked for by the therapist (e.g., the patient reported each and every symptomatic occurrence to his partner, while simultaneously segregating himself from all other persons). In accordance with findings from previous studies (e.g., Grenyer & Luborsky, 1996; Luborsky & Crits-Christoph, 1998; Slonim, Shefler, Gvirsman, & Tishby, 2011), repeated therapeutic incitement to elaborate on these interpersonal associations (as supportive-expressive therapy prescribes) revealed significant past and present contexts. Throughout therapy, recurrent articulation of these contexts progressively elucidated linkages between the patient's tendencies to bottle up irritations towards others, on the one hand, and the start of and evolutions in symptom frequency and intensity, on the other. This process gradually shed light on underlying, frustrated wishes towards others (and its transference in the therapeutic relationship), and on the particular function of the patient's symptom within significant relationships. The gained insight incited the patient to gradually occupy different interpersonal positions within these relationships, and to live up to – previously unrecognized – wishes in a non-symptomatic way, which progressively rendered the function of his symptom redundant. In addition, the therapist's repeated efforts to engage the patient in a joint search for understanding (Luborsky, 1984) constituted new, unfamiliar relational exchanges that satisfied the patient's profound wishes to be understood and to taken seriously. The patient's subsequent sense of a helping alliance and of therapeutic progress increased his involvement in therapy, and lessened his fierce quest for a fellow sufferer. However, at times these changes also raised fears and accompanying resistances that impeded him in the realization of these wishes, and induced temporary symptomatic increases. Throughout the gradual decomposition of old characterizations (during the main part of the therapy) and construction of new identity parts (during the final sessions), the patient progressively managed to organize the symptom's determinations in a coherent story, thereby recounting initially enigmatic experiences in meaningful structures. In line with expectations, this process curtailed the initially fierce ambivalences. Diminished struggles with his needs towards closeness (i.e., to his loving partner) *and* control (i.e., over unreliable others) finally culminated in a new character sketch, which united two irreconcilable tendencies in a newly gained sense of conformity.

In contrast to the symptom specificity hypothesis, but in accordance to previous findings (Cornelis et al., 2016), self-reported interpersonal problems proved to be higher for the *dependent* than for the autonomous sub-profile. Further in line with prior results, CCRT-analyses revealed in addition to the predicted *autonomous* CCRT-components, persistent *dependent* W's to be close to significant others and RS's aimed at gaining their love and desired proximity.

However, while both the previous and current case study of obsessional patients reported co-occurrences of autonomous and dependent CCRT-components, an important point of difference can be noted between the findings. Cornelis et al. (2016) observed these co-occurrences *within each* relationship of the patient under study. Exaggerated tendencies towards autonomy and self-definition proved to be a means of dealing with profound dependent struggles towards all significant others. However, as autonomous strivings were typically accompanied by intense fears of losing others' love, the patient experienced profound *ambivalences* between dependent and autonomous behavior. Subsequently, ambivalence manifested on two levels. On the one hand, repeated alternations between appealing and repelling behavior towards others manifested *within each* relationship. On the other, ambivalence was expressed in intermittent alternations in choosing *between* two equally important relationships he experienced as irreconcilable.

For the current patient, discord between dependency and autonomy also occurred on two levels, but in a different way. First, it was most pronounced in the patient's strict division *between* his current romantic and all other relationships. From the onset of therapy, the patient radically distinguished close and satisfying exchanges with his girlfriend from mutually rejecting interactions with all other people. Central in *all* cited exchanges were wishes to be understood and respected in his "bodily" suffering, and to be helped during panic attacks. In addition, however, interactions with his girlfriend were highly characterized by *dependent* CCRT-components, which did not occur in encounters with others; while the latter revealed profound *autonomous* elements, which were absent in the first-mentioned. Appealing, devoted behavior, on the hand, and aggressive, repelling behavior, on the other, did *not* alternate *within* relationships, but were strictly divided *between* relations and relatively constant within each relationship. Qualitative analysis of the narrative material showed that the patient's obsessional symptom (i.e., panic attacks) functioned as a means of *addressing* his girlfriend in provoking her *care*; while it permitted him to *separate* himself from and install a sense of *control* over all others.

Hence, in contrast to what Cornelis et al. (2016) observed, *ambivalence* did *not* manifest in pressing urges to *choose between* equivalent relationships, nor in capricious behavior *within* each relationship. It did, however, manifest in the patient's difficulties to reconcile two 'parts' of his identity he experienced as opponent. Whereas he had always known himself to be a "people pleaser" towards everyone, both his late aggression towards others, and his so-called "overdependence" towards his current girlfriend, startled him. The shame for these recent dependency issues made him hide behind

a mask of “the assertive, independent man” he displayed to the outside world, and explained the overall higher dependent IIP-32 sub-profile.

Second, *ambivalence* manifested *within* the relationship with his girlfriend, the only one he found important. At the backside of his over-reliance on her, he also hedged himself against it by stubbornly dismissing her most profound wish towards him, i.e., talking more about himself. Repeatedly throughout therapy, *ambivalence* between highly dependent wishes towards closeness, and autonomous tendencies to ward off a feared intrusiveness from her, caused tensions. The presence of multiple interpersonal themes rather than a single predominant core, has previously been reported by, e.g., Crits-Christoph, Demorest, Muenz, & Baranackie (1994). Further consistent with previous findings (e.g., Cornelis et al. 2016; Crits-Christoph & Luborsky, 1990; Vinnars, Dixon, & Barber, 2013; Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004), the patient’s CCRT’s did not change substantially throughout treatment, but increased awareness of the different wishes accompanied more flexible (i.e., less symptomatic) ways of living up to them. In line with expectations, these changes were accompanied by transformations in symptoms, as previously evidenced by, e.g., Cornelis et al. (2016), Crits-Christoph & Luborsky (1998), Grenyer & Luborsky (1996), and Slonim, Shefler, Gvirsman, and Tishby (2011).

Accordingly, self-report questionnaire scores and the patient’s narratives demonstrated significant improvements throughout therapy, both in the patient’s symptomatic and interpersonal functioning, as in his general well-being and health care consumption. In accordance with results from Randomized Controlled Trials and other large-scale studies on the efficacy of psychodynamic therapy (see recent reviews of Fonagy, 2015, and Leichsenring et al., 2015), improvements were maintained at follow-up.

Conclusions, Limitations and Future Research Indications

The present empirical case study aimed to address several conceptual and methodological limitations intrinsic to statistical hypothesis-testing research in cross-sectional group designs, in an effort to further enhance a rich understanding of symptom specificity. In accordance with previous findings (Cornelis et al., 2016), the study did not report a mere interpersonal tendency towards *autonomy* in the obsessional patient, but documented profound *ambivalences* between dependent and autonomous interpersonal behavior. At the conceptual level, we conclude that the replicated finding (within two empirical case studies) of a higher complexity than originally assumed by the classical symptom specificity hypothesis, suggests areas for potential hypothesis refinement.

At the methodological level, we conclude that single case research, in which extensive multiple method and multiple source data sets on one patient are analyzed, is required to grasp the complex, clinical interplay between symptoms and interpersonal dynamics, and to indicate on which points the classical hypothesis needs refining.

However, the suggested complexity needs to be further investigated. Future nomothetic research efforts should aim to test if the proposed refinement can be *statistically generalized* to broader populations of obsessional subjects. Further, endeavors to enhance confidence in the *clinical utility* of the symptom specificity hypothesis, by means of additional (series of) case studies, which more closely resemble everyday practice, are believed to be a necessary complement. Finally, to stimulate further improvements in the theory (e.g., Stiles, 2015), it would be valuable to contrast our findings to results from future longitudinal case studies as to whether (dis)similar patterns can be found in the underlying processes that are responsible for interpersonal and symptomatic alterations (see also Iwakabe & Gazzola, 2009).

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4

EMPIRICAL CASE STUDY 3

INTERACTIONS BETWEEN HYSTERICAL SYMPTOMS AND INTERPERSONAL DYNAMICS THROUGHOUT PSYCHODYNAMIC PSYCHOTHERAPY:

A CASE OF DISSOCIATIVE IDENTITY DISORDER

Controversy about the veracity of dissociation as a distinct clinical entity still dominates present-day literature. From a structural psychodynamic point of view, dissociation is considered to be a typically hysterical symptom and, thus, by the symptom specificity hypothesis (Blatt, 1974, 2004) predicted to be primarily associated with dependent interpersonal dynamics. Inconsistent findings from previous nomothetic research on particular symptom-interpersonal associations have already been associated with conceptual and methodological limitations related to this type of research.

Previous empirical case studies on patients with obsessional complaints (Cornelis et al., 2016; Cornelis et al., under review; see Chapters 2 – 3) have documented particular complexities not initially assumed by the classical symptom specificity hypothesis, and accordingly advanced suggested areas for hypothesis-refinement.

The present case study aims at additional in-depth investigation of symptom specificity, pertaining to hysterical pathology. Similar to previous case studies, Consensual Qualitative Research for Case studies is used to quantitatively and qualitatively describe the longitudinal, clinical interplay between symptomatic and interpersonal evolutions throughout supportive-expressive therapy.

In line with predictions, close associations between symptoms and dependent interpersonal dynamics are observed. Psychodynamic interventions focusing on elaboration of the subjective meanings of (past and anticipated) dissociations, and on working through core interpersonal conflicts, are entailed by transformations in patient's interpersonal stances and subjective well-being. Recurrence of dissociative episodes remains absent unto follow-up assessment three and a half years after treatment termination. Conceptual and methodological considerations, limitations and future research indications are discussed.

Introduction

Since its first description in the nineteenth century (Janet, 1889/1973), the clinical phenomenon of dissociation has always fanned the flames of fascination. To date, however, the diagnosis of 'Dissociative Identity Disorder' (DID; see Diagnostic and Statistical Manual of Mental Disorders, DSM-V; American Psychiatric Association, 2013), formerly known as 'Multiple Personality Disorder' (DSM-III; APA, 1980) remains highly controversial. Debate mainly centers on the status of the disorder as a distinct clinical entity and an accepted scientific concept. From the beginning, a wide variety of dissociative phenomena have been described, ranging from so-called 'normative' dissociative experiences (e.g., Butler, 2006), over temporary, vague feelings of 'unreality' or depersonalisation (e.g., Merskey, 1995), to often-spectacular anomalies (e.g., 'alters' taking over control and behaving differently than the 'dominant' personality), which have inspired imagination in some parts of the psychiatric community, while inciting raised eyebrows in others. Peculiarly, some clinicians (with varying degrees of experience and from miscellaneous parts of the world) diagnose large numbers of cases, whereas others remain unwilling to make the diagnosis, based on their conviction they have never truly encountered multiple personalities in a patient (Merskey, 1995). Recent publications (e.g., Dalenberg et al., 2012; Boysen and Vanbergen, 2013; Lynn et al., 2014) show this controversy is far from settled.

While the veracity of the diagnosis awaits further clarification, DSM-V defines DID as a "disruption of identity characterized by two or more distinct personality states (…) (accompanied by) related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning (…) with recurrent gaps in the recall of everyday events, personal information and/or traumatic events" (APA, 2013, p.261). Present-day literature on dissociation is largely divided by two prevailing, opposing views on its aetiology, coinciding with essentially different treatment models. The posttraumatic perspective (e.g., Gleaves, 1996; Kluft, 1988; Putman, 1989; Ross, 1997), on the one hand, defends DID as a distinct clinical entity, in which fragmentation of the mind is considered to be a defensive reaction to a past traumatic event (e.g., sexual or physical abuse). By directly focusing on this traumatic experience (and working with alter identities), therapy is subsequently presumed to restore the destroyed sense of unity, to obtain a unitary self. On the other hand, the socio-cognitive model (also known as the fantasy model, since its reference to patients' proneness to fantasy and suggestibility; e.g., Lilienfeld et al., 1999; Sarbin, 1997; Spanos, 1994) advocates iatrogenic origins of DID. Proponents of this model reject any causal link with (early life) trauma(ta), but uphold instead that multiple identities or dissociative states mainly boil down to cultural role enactments and social constructs.

Alluring though it may be to elucidate the fierce controversy, the prevailing focus on the veracity of DID threatens to lose a more fundamental issue out of sight, which, however, directly bears

upon clinical practice, i.e., of the subject presenting the symptoms and the particular meanings these symptoms occupy within his/her broader psychic functioning. The rise of the DSM in the second half of the twentieth century (i.e., descriptive approach to psychodiagnostics) eclipsed that the mechanism of dissociation actually originated from studies on hysterical neurosis (Janet, 1889/1973, 1911/1983; Breuer & Freud, 1895/1955). Prior to scientific focus on the static notion of alters, these studies examined the dynamic mechanism of dissociation (besides conversion; Merskey, 1995) as part of the basic hysterical mechanism of repression, as a means to defend against conflicting impulses and desires. Via repression, apparently irreconcilable conflicts are 'resolved' by warding-off psychic material from which the subject henceforward wishes to segregate. The resulting symptoms are sculptured out of this individually warded off material. As such, symptoms are largely excluded from conscious awareness and (to a certain extent) from direct accessibility. In the (less common) case of dissociative episodes, conflicting impulses are literally split off through fragmentation of memory.

Thus, from a structural, psychodynamic point of view, symptoms are not approached as detached, meaningless entities that 'fall upon' the subject at arbitrary moments in time, or as undividedly shared by 'fellow sufferers'. The subjective meaning of symptoms within the patient's broader psychic functioning should therefore be at the center of diagnosis and treatment (e.g., Vanheule, 2014). Especially the centrality of interpersonal dynamics to the emergence and maintenance of psychopathology has long been stressed in psychodynamic research. Identification and description of specific relationship patterns, and their (unique) associations with symptomatology, has consistently been an important research focus. In this respect, Blatt's symptom specificity hypothesis (1974, pp. 155-157) discerns two major interpersonal styles as distinctively associated with different types of neurotic symptoms. On the one hand, the *dependent* style is theorized to be related to bodily symptoms (e.g., somatization and conversion reactions) and phobias, seen as exaggerated attempts towards closeness to significant others. The *autonomous* style, on the other, is hypothesized to be associated with obsessive-compulsive symptoms (e.g., obsessional ideas, compulsions, pathological doubt, and inhibition), considered as exaggerated attempts to install a sense of self-definition and separation towards others.

In order for theories to be both clinically useful (i.e., inform every day clinical practice) and scientifically beneficial (i.e., provide coherent and precise accounts of the studied phenomena), they need to be empirically tested by means of research endeavors that enable to indicate areas where these theories potentially need to grow (e.g., Stiles, 2009). More specifically, it has been asserted that useful clinical theories need to account for *patterns* across multiplex psychotherapeutic processes, as well as *variations* in the concrete applicability of group-based results to *idiographic* contexts of every day clinical practice, where manifold, dynamic determinants operate in continuous processes (in which non-academic consumers of research are specifically interested; e.g. Flyvbjerg, 2006; McLeod, 2013; Stiles, 2009).

Over the past decade, the symptom specificity hypothesis (Blatt, 1974, 2004) has been put to the test in several cross-sectional group studies, but failed to provide consistent findings (for a review, see Desmet, 2007). This inconsistency has previously been advocated as possibly due to several conceptual and methodological limitations intrinsic to the nomothetic research designs of these studies (see Cornelis et al., 2016). On a conceptual level, it was asserted that the concretely tested operationalizations of the classical symptom specificity hypothesis potentially yielded important underestimations of the complexity of associations (see also Desmet, 2013). Essentially, Blatt's theory aims at describing complex, clinical interplays between symptomatic and interpersonal characteristics over time. Thus, methodologically, sound investigation into these dynamics requires longitudinal, clinical data that allow co-variations to be studied throughout the course of a therapy process. Up until now, however, all studies on symptom specificity (1) were cross-sectional in nature and described *static* associations; (2) centered on model, *invariant* patterns in participant groups, thus providing abstract, rule-based knowledge in which within-subject variability and (significant) contextual factors had been disregarded as noise or error; (3) solely relied on patient-reported, quantitative assessment of symptomatic and interpersonal well-being, which have previously been argued to be subject to a variety of biases (e.g., Schwarz, 1999; Desmet, 2007).

Hence, rather than focusing on additional statistical tests of the symptom specificity hypothesis, Cornelis et al. (2016) concluded that there first might be a need to *refine* it on some points. As empirical case research covers important areas that might be overlooked in nomothetic designs (see Iwakabe & Gazzola, 2009), it specifically allows for hypothesis-refinement and 'theory building' (Stiles, 2009) in a distinctive and clinically useful way (Edwards, Dattilio & Bromley, 2004; McLeod, 2013). By integrating intra- and extra-therapeutic contextual influences into thick descriptions of naturally unfolding processes over time, rigorously conducted case studies bear the ability to extend de-contextualized, group-based knowledge on established theories.

Aims and hypotheses

In an attempt to meet the raised shortcomings, Cornelis et al. (2016) asserted a research methodology (discussed below) specifically tailored to address dynamic symptom-interpersonal associations throughout longitudinal treatment processes. The present study specifically applies this methodology to investigate symptom specificity in an empirical case study of the successful treatment of a patient suffering from dissociations. Treatment took place in a real-world clinical practice and was conducted according to Luborsky's (1984) manual of supportive-expressive psychodynamic therapy. In concrete, the study's aim is two-fold: (1) To specifically test concrete operationalizations of the classical symptom specificity hypothesis (see below); (2) To richly investigate and describe the gradual unfolding of dynamic interactions between patient's symptomatic and interpersonal functioning throughout the treatment process.

Consensual Qualitative Research for Case Studies (CQR-c; Jackson, Chui, & Hill, 2011) is applied as an overarching data-analytic approach. The triangulation process (i.e., addressing the data through multiple angles in a team of researchers, and installing a broad dialogue between team members until all agree on the best representation of the data) significantly contributes to 'credibility' of the results (Morrow, 2005) and results in more meaningful understanding of the data (Dattilio, Edwards & Fishman, 2010).

To provide conformity between the supportive-expressive treatment under study (Luborsky, 1984), and empirical investigation of the narrative data extracted from this treatment, Core Conflictual Relationship Theme methodology (CCRT; Luborksy & Crits-Christoph, 1998) is conducted to study the patient's interpersonal functioning. This method is based on the theory (Luborsky, 1962) that a subject's relational exchanges are generally underpinned by a typical 'core conflict', which is compromised of three major components (Luborsky & Crits-Christoph, 1998): (1) the 'Wishes' (W) with which the subject enters relational exchanges; (2) the subject's appraisal of how the other person reacts to these wishes ('Responses of Other', RO); (3) his/her own reactions to these ROs ('Responses of Self', RS). Since symptoms are rooted in the patient's core conflict, psychotherapeutic endeavors focusing on transformation of this core conflict are theorized to bring about symptomatic alterations (Luborsky, 1962, 1984), as previously evidenced by e.g., Grenyer and Luborsky (1996), Luborsky and Crits-Christoph (1998), and Slonim, Shefler, Gvirsman, and Tishby (2011).

Aiming to record various aspects of (the broad spectrum of possible changes in) the studied phenomena (e.g., Hill, Chui, & Baumann, 2013), extensive multiple method and multiple source data sets were analyzed. The patient's symptomatic and interpersonal functioning was assessed regularly during treatment and follow-up, both quantitatively and qualitatively, from perspectives of patient, therapist and researchers. Symptoms and associated psychic distress were additionally measured via saliva cortisol concentrations (i.e., hormonal biomarkers of distress) and health care costs (i.e., information on all mental and physical health related expenses, and job absenteeism; see, Method).

Recently, this combination of CQR-c and CCRT-methodology in the study of symptom specificity has been applied in two previous empirical case studies of patients with obsessional complaints (Cornelis et al., 2016; Cornelis et al., under review). Illuminating complexities that were not readily captured by the classical symptom specificity hypothesis, these studies resulted in a suggested refinement. In line with the classical hypothesis, close associations were observed between the patients' symptomatic and interpersonal functioning, and between therapist interventions focusing on interpersonal conflicts and symptomatic alterations. Contrary, however, to the predicted predominance of autonomous interpersonal tendencies, the patients' obsessions proved to be embedded within profound ambivalences between dependent and autonomous behavior. The suggested complexity is in accordance with the hypothesis' more complex theoretical underpinnings (e.g., psychodynamic theories of Freud, Lacan, Blatt, Luborsky).

To further enhance a rich understanding of symptom specificity, the present 'theory-building' case study (Stiles, 2009) will further explore clinical complexity of associations between dissociative (i.e., hysterical) symptoms and specific interpersonal dynamics.

Hence, operationalizing interpersonal characteristics by means of the CCRT-method, the classical symptom specificity hypothesis (Blatt, 1974, pp. 155-157) leads up to the following **predictions** with respect to symptomatic-interpersonal associations in the patient under study:

H1: Before therapy (during the intake phase) we expect dissociative symptoms to be accompanied by a dependent interpersonal style, expressed in an exaggerated emphasis on interpersonal relatedness and closeness to others.

H1a: Quantitatively, we expect the patient will show an overall higher dependent than autonomous sub-profile on the Inventory of Interpersonal Problems (IIP-32; see Desmet, Meganck & Vanheule, 2013).

H1b: Qualitatively, we expect the following CCRT-components (Luborsky & Crits-Cristoph, 1998, p.46-48) to underpin the patient's relational exchanges: 'Wishes' to be respected, liked, dependent, close, have trust, help, be helped, avoid rejection, not be hurt; a particular sensitivity to the following 'Responses of Other': distant, not accepting, hurting, not trustworthy, not cooperative, and disliking the subject; triggering the following 'Responses of Self': feel dependent, uncertain, disappointed, angry, depressed, unloved, anxious.

H2: Throughout therapeutic process, we expect supportive-expressive therapy to reduce exaggerated strivings towards interpersonal closeness, and dissociative symptoms to subsequently diminish.

H2a: Quantitatively, we expect that scores on the IIP-dependent profile will decrease progressively throughout therapy, and that decreasing IIP-scores will be correlated with declining scores on symptomatic and general ill-being.

H2b: Qualitatively, we expect that changes in the dependent CCRT's throughout therapy (particularly in the RO- and RS- components, e.g., Crits-Christoph & Luborsky, 1990; Grenyer & Luborsky, 1996) will be accompanied by changes in dissociative symptoms.

Method

Participants

The patient was a 24-year old Caucasian man who suffered from periodic episodes of dissociation, during which he exhibited singular behavior he did not (or only dimly) recall during his conscious state of mind, but for which factual evidence was indisputable. He was a secondary school graduate and worked as a salesman in IT business. At intake, he met *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) criteria of Dissociative Identity Disorder (axis I; no personality disorder was diagnosed on axis II). Patient

provided written informed consent (approved by the University Ethics Committee) to participate in the study and to publish the individual case materials. All possibly identifying information has been changed to protect confidentiality.

The therapist was a 34-year old Caucasian, man, who held a PhD in clinical psychology, received three-year postgraduate training in Freudian-Lacanian psychoanalytic psychotherapy, and had six years of clinical experience at the start of therapy.

The research team that carried out the data-analyses consisted of two assistant professors (one male, one female), two postdoctoral researchers (one male, one female), and two female PhD students. They were all trained or following training in Freudian-Lacanian psychoanalytic psychotherapy. All research members were Caucasian and ranged in age 24-35 years.

Therapy

Patient received 41 (40- to 60-minute) sessions of supportive-expressive psychoanalytic psychotherapy (Luborsky, 1984) over 11 months, conducted in the therapist's private practice without interference of the research team. Session frequency varied between twice a week and once every three weeks, with an average frequency of once a week (see Figure 1). In-depth discussion of the therapeutic process, including specific examples of supportive and expressive techniques, is provided in Results Step 3.

Measures

Symptoms and General Well-being.

The General Health Questionnaire - 12 (GHQ- 12; Goldberg, 1972; Koeter & Ormel, 1991) is a 12-item self-report questionnaire used to assess general psychological distress. Items are scored using a 4-point Likert scale. The GHQ's validity and reliability was demonstrated by Koeter and Ormel (1991), and by Vanheule and Bogaerts (2005) for the Dutch version.

The Symptom Checklist - 90 - Revised (SCL-90-R; Derogatis, Lipman, & Covi, 1973) is a 90-item self-report questionnaire assessing general psychological and physical functioning with good psychometric qualities (Derogatis, 1994). Items are scored on a 5-point Likert scale.

The Global Assessment of Functioning (GAF; APA, 1987) scale is a widely used clinician- or researcher rated measure of psychiatric symptom severity and functioning on a psychological, social and occupational level. The scale can be used to track clinical progress of individual patients in global terms. The overall GAF scale scores range from 0 to 100 and are divided into ten deciles of functioning. GAF rating involves selecting one single decile that best reflects the patient's overall level of functioning at the time of evaluation.

Saliva stress hormone levels. Concentrations of cortisol (µg/dl) were measured in saliva samples by means of mass-spectrometry. At different time points during therapy (see Procedure below), a series of saliva samples was gathered, following the standard practice in salivary hormone research (e.g., Kirschbaum, Bartussek, & Strasburger, 1992). Cortisol –popularly termed "the stress hormone" – is considered a biomarker of an activated stress response. It plays a key role in numerous

models that link (chronic) stressors to psychiatric as well as medical disease (Miller, Chen, & Zhou, 2007).

Health care costs. Via the patient's health insurance fund all health care costs were retrieved, spanning from four years before treatment onset until follow-up 3 years and 4 months after treatment termination. Costs include medication use (i.e., psychotropic and other), medical consultations (ambulant and residential, excluding the psychotherapy sessions discussed in this paper) and job absenteeism.

The Semi-structured Change Interview (SCI; Elliott, 1999; Elliott, Slatick, & Urman, 2001). This in-depth qualitative outcome interview was administered by a researcher at follow-up (3 years and 4 months after treatment termination) and is used to assess the way the patient experienced the therapeutic process. The patient is asked about what changes occurred during therapy, the processes that might have brought about these changes, whether any of the changes were surprising to him/her, and what aspects of the therapy he/she experienced as helpful, difficult, hindering, or missing.

Interpersonal Functioning.

The Inventory of Interpersonal Problems - 32 (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000) is a 32-item self-report questionnaire with eight subscales reflecting different interpersonal problems. Items are scored on a 5-point Likert scale. Psychometric properties of the Dutch version were positively evaluated by Vanheule, Desmet, and Rosseel (2006). Desmet et al. (2008) developed a scoring system for an anaclitic/hysterical and an introjective/obsessional IIP profile.

The Core Conflictual Relationship Theme (CCRT) Method (Luborsky & Crits-Christoph, 1998) is a qualitative, systematized and reliable measure of the central relationship patterns that pervade self-other interactions (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2000). Within the patient's narratives, two researchers selected Relationship Episodes (RE's), i.e., discrete episodes in which the patient spontaneously spoke about concrete relational exchanges, decomposed in (see Introduction): (1) 'Wishes' (W), (2) 'Responses of Other' (RO), and (3) 'Responses of Self' (RS). The most typical W's, RO's and RS's constitute the final CCRT-formulation.

Procedure

Data collection happened as follows: (1) therapy sessions were audiotaped by the therapist, and transcribed verbatim by a postgraduate research assistant; (2) after every session (2a) patient completed GHQ-12 and IIP-32 questionnaires in the therapy room in presence of the therapist, and (2b) therapist made a brief session report in which he summarized important dynamics at the level of symptomatology and interpersonal functioning; (3) after the first session, after every eighth session, and at follow-up (i.e., 3 years and 4 months after treatment termination) (3a) patient completed a more extensive set of questionnaires at home (i.e., GHQ-12, IIP-32, SCL-90, BDI-II) and provided a set of 8 saliva samples (gathered on 4 consecutive days prior to the day questionnaires were filled out; one morning and one evening sample each day), and (3b) GAF-scores were administered by a research team member; (4) at follow up, SCI was administered by a research team member, and health care cost information was retrieved.

Data analysis

Data-analysis included three main steps (as previously been described in Cornelis et al., 2016): a quantitative and qualitative outline of (Step 1) symptomatic evolutions throughout therapy, (Step 2) evolutions in interpersonal functioning, and (Step 3) their associations, embedded within a broader, clinical description of the therapy process.

In Step 1, one member of the research team (referred to below as 'researcher 1') constructed graphs on quantitative evolutions in all outcome measures of symptoms and general well-being (see Figures 1 and 2). To assess significance of change, the ACORN Toolkit (specifically designed to help clinicians and researchers calculate change related statistics for a variety of outcome measures; Brown, Simon, Cameron, & Minami, 2015) was used to calculate Reliable Change Indices (RCI; identical to RCI formula of Jacobson and Truax, 1991, but with one-tailed 95% confidence intervals; see Brown et al., 2015) and severity adjusted effect sizes (SAES; Brown et al., 2015). Next, two research team members (i.e., 'researchers 1 and 2') attentively listened to audiotapes and read the transcripts. Both were equally informed of relevant patient demographic information and therapy characteristics (see Hill, 2012), but researcher 2 was blind to quantitative graphs. Both researchers separately identified all events where the patient explicitly referred to his symptoms, and marked symptomatic evolutions throughout therapy with respect to intensity, content or form. Through subsequent discussion on the most profound changes, consensus was reached on identification of the main 'tipping points' (i.e., specific moments in the chronicle of events that turn out to be crucial for further development; Tarrow, 2004). In case of divergence, members engaged in discussions in which they questioned each other on their ideas, so that every opinion was fully expressed and understood (see also Jackson, Chui, & Hill, 2011; Schielke, Fishman, Osatuke, & Stiles, 2009) until both members agreed on the best representation of the data (Hill, Thompson, & Williams, 1997). A concise qualitative description of symptomatic evolutions was provided by researcher 1, reviewed by a third team member (familiar with the raw narrative data), and consequently refined.

In Step 2, researcher 1 constructed similar graphs on evolutions throughout therapy in interpersonal characteristics (see Figure 3), measured by IIP-32 total scores, and dependent and autonomous IIP-32 sub-profiles (see Vanheule, Desmet, & Rosseel, 2006). Again, RCI and SAES were computed using the ACORN Toolkit (Brown et al., 2015) to assess significance of change. Next, researchers 1 and 2 conducted CCRT analyses for the first therapy sessions, the 'tipping point'-sessions selected in Step 1, and the last sessions. In a first phase, both researchers attentively re-read transcripts of the identified sessions, individually selected all RE's that were suitable for CCRT coding (i.e., RE's that contained W's, RO's and RS's), and gathered to select by consensus the 10 most informative RE's. When sessions yielded less than 10 informative RE's, additional RE's were selected from the preceding and/or following sessions. In a second phase, selected RE's were then written down in a separate document and coded using the standardized coding system (Standard Category List, Edition 2; Luborsky & Crits-Christoph, 1998, p.26). In line with Hill et al. (2011), judges distinguished between (a) RE's describing interactions with *specific people*, and with *people in*

general, (b) W's, RO's and RS's occurring in *all* RE's (General, G), in *at least half* of RE's (Typical, T), and in *less than half, but at least two* RE's (Variant, V). Researchers strived towards consensus on identified RE's (phase 1) and CCRT-codes of identified RE's (phase 2). In case of divergence, researchers engaged in extensive discussions (see Step 1), and gradually refined initial ratings by integrating valuable contributions of the other until consensus codes were reached (see Hill, 2012). Judges' proportions of agreement (RE's: .93, W's: .80, RO's: .89, RS's: .70) indicated high correspondence for initial ratings. Finally, researcher 1 organized consensus CCRT-codes in Tables 1 – 3, which were checked for accuracy and comprehensiveness by researcher 2.

In Step 3, researcher 1 calculated longitudinal intra-subject associations (i.e., correlations between two series of repeated measures within the same subject) between evolutions in patient's symptomatic, general and interpersonal level of functioning. Next, researcher 1 engaged in a 'thick description' (Pontoretto & Grieger, 2007) of the longitudinal, clinical interplay between both levels throughout therapy, in which changes in quantitative measures were linked to the treatment narrative (Dattilio, Edwards, & Fishman, 2010) and significant therapist interventions and extra-therapeutic events were discussed. Several precautions were taken to reduce researcher 1's biases and expectations and to present a 'truer' account of the data (see Hill, 2012): prior to writing, researcher 1 orally presented provisional analyses to a third research team member (unfamiliar with the case data, but acquainted with the theoretical orientation and phenomena of interest, and informed about the research questions), who extensively questioned her in order to focus findings more clearly in response to research questions; during the writing process, researcher 1 continually returned to raw materials to stay close to the patient's narratives, and included sufficient detail and literal quotes of the patient to validate presented findings; finally, the manuscript was reviewed several times by three team members (i.e., the one described above, and two who were familiar with the case data and research questions) to identify areas in need of further attention, which were subsequently refined.

Results

Step 1: Evolutions in Symptomatic and General Well-Being

Analysis of Outcome Data. Figure 1 shows an overall decreasing trend over the course of therapy, in *self-reported* general psychological and physical malfunctioning (GHQ-12 and SCL-90 scores), in *researcher-rated* psychological, social and occupational ill-being (GAF-scores), and in *biological* cortisol concentrations. Decreases in self-reports reached significance when assessed by means of RCI, both at treatment termination (GHQ-12: RCI = -14.60, $p < .05$; SCL-90: RCI = -11.99, $p < .05$), and at follow-up (GHQ-12: RCI = -11.30, $p < .05$; SCL-90: RCI = -12.33, $p < .05$). In addition, large SAES were observed at treatment termination (GHQ-12: $d = 8.76$; SCL-90: $d = 2.94$) and at follow-up (GHQ-12: $d = 6.78$; SCL-90: $d = 3.02$). Changes are maintained at follow-up, yet, cortisol concentrations rise again to early-treatment levels, and GHQ-12 scores slightly increase (but still coincide with a large effect size).

Several peak values can be noted during treatment. As addressed in Step 3, GHQ-12 scores – marking general distress – peaked during sessions 2, 7, 11, 15, and 20.

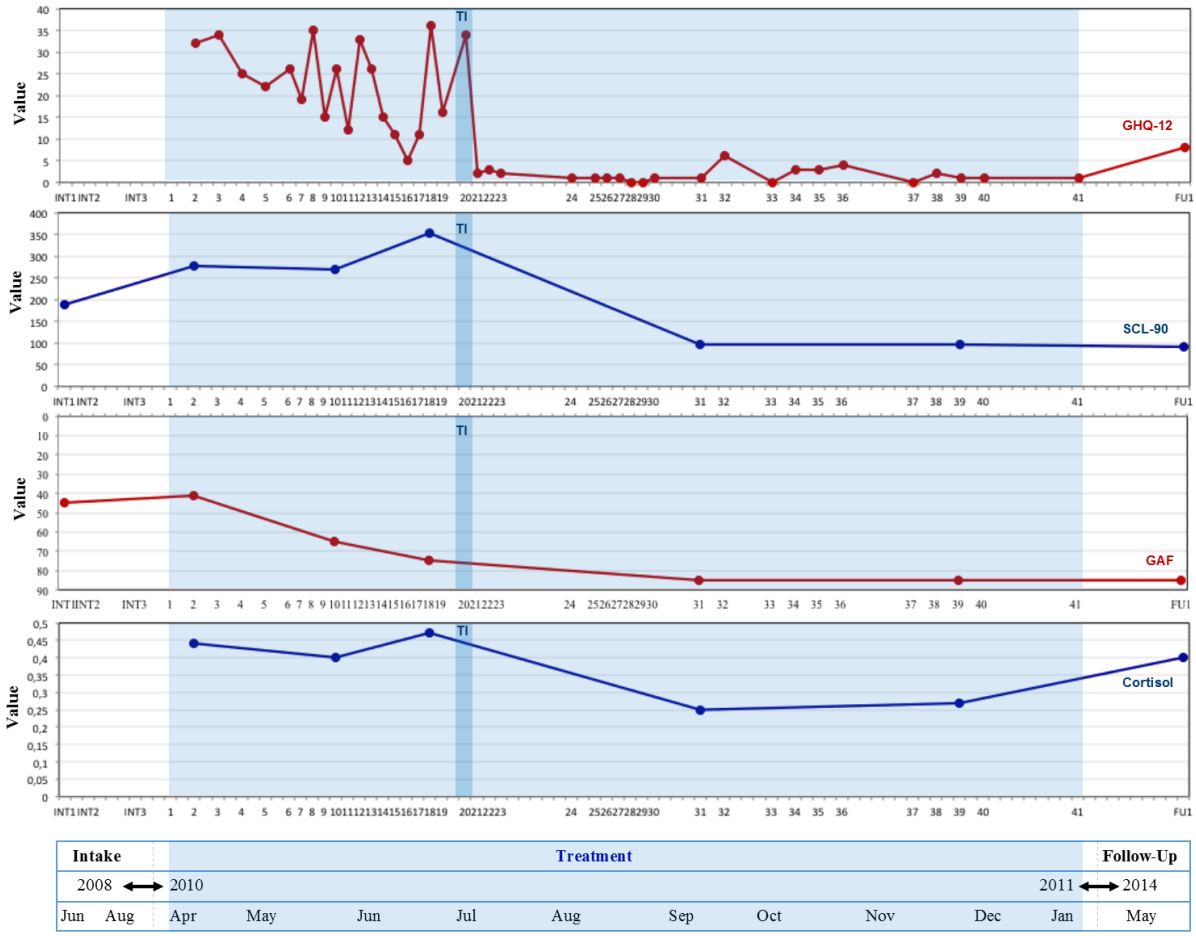

Figure 1. Evolutions in patient- and researcher-rated well-being and saliva cortisol concentrations from intake to follow-up. GHQ-12 = General Health Questionnaire-12; SCL-90 = Symptom Checklist-90-Revised; GAF = Global Assessment of Functioning; TI = Tipping point session; Cortisol values: µg/dl.

Next, Figure 2 depicts a variety of health care costs made in a period spanning from four years before the onset of treatment until follow-up. The first peak (December 2007) reflects costs due to dentist consultations. The second peak (December 2010) depicts expenses during to the two-day hospitalization after the patient's suicide attempt (i.e., between sessions 19-20). The last peak period (June 2012 – January 2013) refers to costs of multiple medical analyses performed on the patient's daughter prior to her death (thus, not reflecting his individual health care usage). There were no periods of job absenteeism due to a physical or psychological condition.

In terms of average health care costs per month, costs were highest during the treatment period (€91/month; owing to the above-mentioned peak in outlined costs related to the patient's suicide attempt, apart from which no health care usage was registered during therapy), compared to pre-treatment (€22/month) and post-treatment (€51/month; during which the only costs reflected his daughter's health care usage).

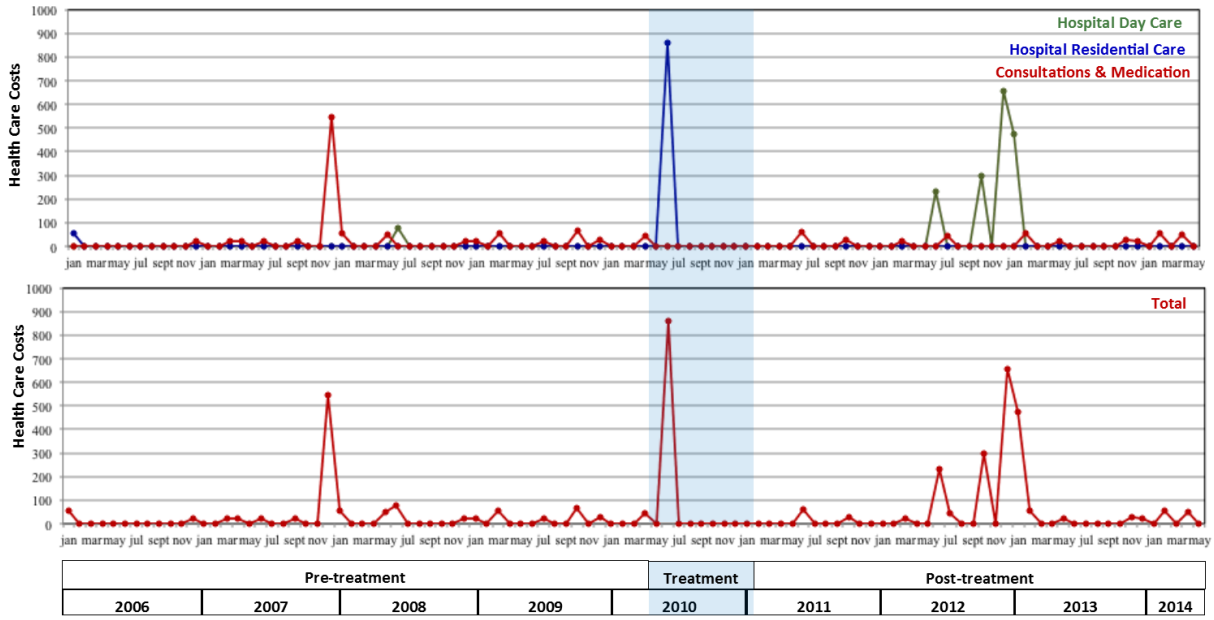

Figure 2. Evolutions in patient's health care costs (euro) from four years before onset of treatment until follow-up.

Qualitative Description of Evolutions. Preliminary note: since subjects' natural language "more closely represents the psychological reality of human experience" (Camic, Rhodes, & Yardley, 2003), literal wordings of the patient (designated by double quotation marks) are quoted to enforce researchers' remarks.

Following one year of couple therapy with his girlfriend Rebecca, James was referred for individual treatment owing to a recent dissociative episode, during which he had exhibited singular behavior he had no memory of afterwards (see Step 3), but for which factual evidence – provided by his girlfriend – was indisputable. Yet, rather than blanks in his memory of the night the dissociation had occurred, James described he "had a completely different story in my head of what happened that night" of which he "was fully convinced".

However, as his relationship with Rebecca had steadily ameliorated over the last months of couple therapy, James had quit both therapies (i.e., after three individual sessions), but returned for individual treatment one year and eight months later, following a second dissociative episode, which had again been discovered by his girlfriend. Despair about the end of his relationship, combined with intense feelings of uncertainty, confusion and instability (e.g., "I can no longer be sure of anything or anyone", "I cannot trust myself anymore", "who knows what else I might have done in my life without knowing about it") had mobilized suicidal ideas. He hated himself for what he had done during the past dissociative episodes and was frightened he would uncontrollably keep dissociating for the rest of his life. Slightly reassured by the therapist (see Step 3), suicidal ideas diminished at the onset of therapy.

During the course of therapy, James also reported phenomena that have previously been described as associated with DID (see Merskey, 1995), i.e., having puzzling, longstanding "gaps" in his memory of childhood events prior to the age of fifteen years; equally longstanding periods of "feeling unreal" and vaguely "sensing that something is not right, but now knowing what or why". In

addition, he reported occasional migraine attacks (occurring “once every three weeks”) due to a vague “restlessness” (i.e., without being able to ascribe it to certain triggering factors); longstanding periods during secondary school of “feeling chronically low-spirited”, “leading a meaningless life, having no future prospects” (e.g., “I could not care less about my future”) and recurrently failing school tests (i.e., “I always block while taking a test”, yet, without knowing why, and thus ascribing it to “intense fear of failure”), despite “often-excellent performance during lessons,” which incited teachers “to have a very high opinion of me; and a psychiatric hospitalization (where he had met Rebecca) after quitting college, four years prior to the onset of treatment.

During therapy, changes took place in James’ coping with past dissociative episodes, which were no longer the central focus of discussion from session 2 onwards, unless initiated by the therapist. Dominant themes were instead: profound feelings of abandonment, imbalance and worthlessness that monopolized his inner world. Up to session 12, James reported declined occupational functioning, intense sleeping problems, neglect of self care (e.g., barely eating, bathing or dressing properly), loss of energy, and limited social engagement (i.e., restricted to desperate attempts to “get Rebecca back”). Only the (positively experienced) concerned reactions from colleagues incited him to get up in the mornings. During sessions 7, 9, 10 and 11, he described temporary, minor upsurges in his well-being and renewed (though feeble) feelings of “having more grip on what is happening”. In session 12, however, the news that Rebecca had already engaged in a new romantic relationship put him off balance again and briefly revived suicidal ideas. Yet, as depicted in Figure 1, his state ameliorated again between sessions 13 – 20: he rebuilt former friendships, started going out again, slept better, increasingly took care of himself, regained the “drive to move on and make something of my life”, set new occupational and personal ambitions (e.g., resuming the studies he had interrupted in college), and experienced novel feelings of “inner calm” and “matureness”. However, in session 18, numerous enjoyable contacts with his former “soul mate” Holly incited feelings of “guilt” and “confusion” (since “it is a completely different, unprecedented type of feeling good”). Then, during the week preceding session 20 (i.e., *tipping point* session), James made a (failed) suicide attempt after the umpteenth rejection of Rebecca. His initial disappointment of having been unsuccessful, however, soon made room for remarkable positive changes in his general and interpersonal well-being that remained stable until follow-up (see Figures 1 and 3). He engaged in a romantic relationship with Holly, widened his social network, increasingly described novel feelings of happiness, purposiveness, energy, calm and self-worth, no longer suffered from head aches, successfully passed examinations at work, and progressively started to reminiscence significant childhood events (see Step 3).

Though most childhood memories had remained blank and clear images of what had happened during the past dissociative episodes had not recurred throughout therapy, James’ stance towards these gaps had changed considerably: “I used to have a hard time assuming what has happened, but now I can peacefully embrace the way things have turned out”. His terror that dissociations would frequently and uncontrollably reoccur throughout his life, had similarly vanished (see Step 3). After contentedly declaring that “everything is falling into place,” a new appointment was yet scheduled, but James did not show up anymore. During the follow-up interview three and a half

years later, he affirmed maintenance of described therapy gains, gladly expressed that no new dissociative episodes had occurred since, and additionally acknowledged “a much more mature manner of dealing with things”. Specifically referring to Holly’s miscarriage two years after treatment termination, he contrasted Holly’s profound difficulties to cope with this loss to his own, fitter way of coping with grief (see slight increase in GHQ-12 and cortisol values in Figure 1).

Step 2: Evolutions in Interpersonal Functioning

Analysis of Outcome Data. Similar to Figure 1, Figure 3 shows a generally descending trend in IIP-32 scores throughout therapy and during follow-up, which reaches significance when assessed by means of the Reliable Change Index (at treatment end: RCI = -9.47, $p < .05$; at follow-up: RCI = -8.65, $p < .05$) and corresponds with large severity adjusted effect sizes (at treatment end: $d = 3.79$; at follow-up: $d = 3.46$). Scores for the dependent sub-profile are overall higher than for the autonomous sub-profile. As addressed Step 3, peak values (i.e., increasing interpersonal problems) are observed in sessions 4, 18 and 20.

Analysis of CCRT-codings.

CCRT’s in RE’s with Specific Others.

With Rebecca (girlfriend at start therapy). Up to session 20 (*tipping point* session), James’ “whole world turned around Rebecca”. Despite having had a large social network prior to the start of their relationship, he had severed ties with all his friends since (e.g., “I had Rebecca and that was enough”). James generally wished (W) to be close to her, respected and loved by her, but typically experienced her (RO) as frustrating those wishes (e.g., distant, rejecting, not understanding), which made him feel (RS) disappointed, dependent, unloved, and depressed. Occasional “outbursts” of anger (RS), frequent arguments (RO, RS) and periods of “not knowing what to say to each other” (RO, RS), had prompted them to start couple therapy two years before the onset of James’ individual therapy. When he and Rebecca eventually split up, his world collapsed: he experienced intense difficulties to let go of her, exhibited overly dependent behavior and made a suicide attempt (RS). From session 20 onwards *(tipping point* session*)*, this condition changed remarkably. Mounting dissatisfaction (RS) with her rejecting and compelling RO’s (set in motion by profound contrasts with positive RE’s with his new love Holly) inclined him to progressively embrace their dried up relationship (reflected in the steep decrease in RE’s in Tables 2 and 3).

With Patricia/with Zoë. Throughout therapy, James regularly recounted past RE’s with his ex-girlfriends Patricia and Zoë to underline a pattern in interpersonal exchanges with former partners, which prolonged in his relationship with Rebecca. This pattern was marked by profound wishes (W) to be close, loved and respected; frustrating RO’s of distance, disrespect and abuse of his generosity; and generally negative and overly dependent RS’s.

With Holly (girlfriend from session 21 onwards). During therapy (i.e., after the split-up with Rebecca), James renewed contact and soon engaged in a romantic relationship with his former “soul mate” Holly, whom he described as (RO) his “female counterpart”, i.e., they “spoke the same

language" and "understood each other completely". In great contrast with former engagements, he experienced their relationship as more differentiated and reciprocal (RO, RS): while he described RO's of closeness, love, cooperation, trust, and mutuality, he also experienced her as "allowing me independence"; which incited feelings of trust and security (RS), and entailed a steep increase in his life ambitions, happiness and purposiveness (RS).

With mother. In early sessions, James mainly recounted past, wish-frustrating RE's with his mother (not presented in Table 1 due to lack of RE's containing all CCRT-components), who had consistently neglected (RO) to stand up for her children whenever they had been treated unjustly by his father; which made him feel disappointed, unloved and abandoned (RS). In being very secretive about "what was going on in the family" (see Step 3) and "never confiding anything in me", his mother "has always treated me like a child" (RO). Yet, her (unexpected) concerned and caring RO's following his suicide attempt (session 20) mobilized novel RE's characterized by mutual respect and openness (RO, RS).

Table 1
Patient's wishes (W), responses of other (RO), and responses of self (RS) in sessions 1 – 3

Target of interaction	#	W	RO	RS
Rebecca	6	Be close (G), be respected (be important to/be treated fairly; T), not be hurt (V), be helped (taken care of; V), be loved (V), be opened up to (V)	*Negative:* Distant (G), rejecting (T), not understanding (V), doesn't respect me (V), not trustworthy (V), hurt (V) Positive Loves me (V), helpful (V)	*Negative:* Disappointed (G), dependent (T), unloved (T), depressed (T), angry (V), uncertain (V), guilty (V) *Positive:* Understanding (V), helpful (V)
Patricia	2	Be loved (G), be close (G), help (G), be respected (G)	*Negative:* Rejecting (G), distant (G)	*Negative:* Dependent (G), unloved (G), depressed (T) disappointed (T), anxious (V)
Across all interactions	10	Be respected (T), be close (T), be loved (T), help (V), not be hurt (V), be helped (V), be opened up to (V)	*Negative:* Rejecting (T), distant (T), not trustworthy (V), not understanding (V), don't respect me (V) *Positive:* Love me (V), helpful (V)	*Negative:* Disappointed (T), dependent (T), unloved (T), depressed (T), angry (V), uncertain (V), disappointed (V), anxious (V) *Positive:* Understanding (V), helpful(V)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Number of "Across all interactions"-exchanges equals the sum of Relationship Episodes with specific, significant others as presented in the table, added by narrated Relationship Episodes with others that did not significantly recur in patient's narratives.

CCRT's Across All Interaction Patterns. In early sessions, James typically wished (W) to be respected, be close to, and be loved and included by others (likewise reflected in his dominant professional strivings, see *RE's with colleagues and boss*; and in familial contacts, see *RE with brother Harry*); but typically experienced others (RO) as rejecting and distant; provoking feelings of (RS) disappointment, dependency, depression and being unloved. He described relations with others to be "mainly based on problems", i.e., he wished to "help others who were in need of discussing their problems", so as "to distract from my own problems", which he bottled up (see 'compulsive caregiving', Blatt, 2008, p.175). Throughout therapy, James increasingly wished (W) to be opened up to and to

assert himself in contact with others; notably experienced more positive RO's of respect, love, care and cooperation (except for – current and past – RE's with Rebecca, Patricia and Zoë); and increasingly described RS's of self-confidence, happiness, comfort and love. During the last therapy sessions and follow-up interview, James repeatedly accentuated the experienced evolution during therapy from "black or white" relationships (i.e., swiftly judging others as to like or to dislike very intensely, "no in between") and compulsive, self-effacing caregiving to significant others, towards "more balanced" relationships, which were increasingly based on "sharing problems *and* joy", and in which he increasingly asserted his own needs ("though I will always remain the James who likes to care for others").

Table 2
Patient's wishes (W), responses of other (RO), and responses of self (RS) in sessions 20 – 22

Target of interaction	#	W	RO	RS
Holly	5	Be close (G), be respected (T), be liked (V), be good (V), be my own person (V), to respect her (V), to accept her (V), be open (V), be opened up to (V), be understood (V)	*Positive:* Respects me (G), open (T), likes me (V), helpful (V), loves me (V), gives me independence (V), happy (V), accepts me (V), anxious (V), understanding (V)	*Negative*: Uncertain (V) *Positive*: Comfortable (G), happy (T), loved (T), respected (T), independent (T), accepted (V), open (V), self-controlled (V)
Rebecca	2	Be respected (be valued, important to; G), be close (G), be loved (G)	*Negative:* Not trustworthy (T), distant (T), rejecting (T) *Positive:* Respects me (T)	*Negative*: Disappointed (G), angry (T), hurt her (T), out of control (T), dependent (T), uncertain (T), unloved (T) *Positive*: Independent (T), respected (valued; T), helpful (T), controlling (T)
Colleagues	1	Be respected (G), be liked (G)	*Positive:* Respect me (T), love me (T), helpful (T), anxious (worried; T)	*Positive*: Respected (G), controlling (G), comfortable (G), loved (G)
Boss	1	Be respected (G), be close (be included; G)	*Negative:* Not trustworthy (G)	*Negative*: Anxious (G), jealous (G), disappointed (G)
Mother	1	Be understood (G), be accepted (G), be respected (valued, important to; G), be liked (interested in me; G)	*Positive:* Understanding (G), accepting (G), helpful (G), respects me (G), anxious (worried; G)	*Positive*: Respected (G), accepted (G), open (G), comfortable (G), loved (G) *Negative*: Uncertain (G)
Across all interactions	10	Be respected (T), be close (T), be liked (T), be understood (V), be accepted (V)	*Negative:* Not trustworthy (V), rejecting (V) *Positive:* Respects me (T), helpful (V), accepting (V), likes me (V), open (V), loves me (V), understanding (V), gives me independence (V), anxious (V), happy (V)	*Negative*: Uncertain (T), disappointed (V), hurt (V), out of control (V), dependent (V), uncertain (V), unloved (V), anxious (V), jealous (V) *Positive*: Respected (T), comfortable (T), loved (T), happy (V), independent (V), accepted (V), open (V), helpful (V), controlling (V)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Number of "Across all interactions"-exchanges equals the sum of Relationship Episodes with specific, significant others as presented in the table, added by narrated Relationship Episodes with others that did not significantly recur in patient's narratives.

Table 3
Patient's wishes (W), responses of other (RO), and responses of self (RS) in sessions 37 – 41

Target of interaction	#	W	RO	RS
Holly	5	Be respected (be valued, important; G), be close (T), assert myself (T), have control (V), be opened up to (V), feel comfortable (V), not be held responsible (be obliged; V), respect her (V)	*Negative:* Opposing (V) *Positive:* Understanding (T), cooperative (T), respects me (T), gives me independence (T), dependent (influenced by me; V), open (V), accepting (V), helpful (V), anxious (worried; V), loves me (V)	*Negative*: Disappointed (V) *Positive:* Comfortable (T), open (T), self-confident (T), respected (T), loved (T), controlling (V), accepted (V), helpful (V), self-controlled (V), happy (V)
Mother	1	Be opened up to (G), be respected (G), be close (G), have control (G)	*Negative:* Doesn't trust me (G), distant (G), doesn't respect me (G) *Positive:* Open (G), accepting (G)	*Negative:* Disappointed (G) *Positive:* Open (G), controlling (G)
Rebecca	1	Be close (G), be respected (G), respect (G), help (G), have control over (G), be opened up to (G)	*Negative:* Doesn't trust me (G), opposing (G), rejecting (G), doesn't respect me (G), distant (G)	*Negative:* Not open (G), disappointed (G), angry (G), guilty (G), symptom (G)
Harry	1	Be close (G), be respected (G), be accepted (G), be liked (G), be opened up to (G)	*Positive:* Respects me (G), likes me (G), open (G), accepting (G), understanding (G)	*Positive:* Open (G), accepted (G), respected (G), likes him (G), self-confident (G)
Zoë	1	Be respected (G), assert myself (G)	*Negative:* Doesn't respect me (G), bad (G) *Positive:* Likes me (G)	*Negative:* Angry (G), uncertain (G) *Positive:* Self-controlled (G), self-confident (G)
Across all interactions	10	Be respected (G), be close (T), be opened up to (T), assert myself (V), have control (V), respect others (V), be liked (V), help (V)	*Negative:* Don't respect me (V), opposing (V), don't trust me (V), distant (V), out of control (V), bad (V) *Positive:* Open (T), understanding (V), respect me (V), accepting (V), like me (V), cooperative (V), give me independence (V), dependent (V)	*Positive:* Self-confident (T), respected (V), open (V), comfortable (V), self-controlled (V), accepted (V), likes others (V), helpful (V), controlling (V), happy (V), loved (V) *Negative:* Disappointed (V), angry (V)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Number of "Across all interactions"-exchanges equals the sum of Relationship Episodes with specific, significant others as presented in the table, added by narrated Relationship Episodes with others that did not significantly recur in patient's narratives.

Step 3: Associations between Symptomatic and Interpersonal Level

Analysis of Outcome Data. Longitudinal intra-subject correlations between IIP-32- scores on the one hand, and GHQ-12-, SCL-90-, GAF- and cortisol values, on the other, document positive, high associations between the patient's interpersonal dynamics and his symptomatic and general well-being (r = .87 with GHQ-12, p < .01; r = .95 with SCL-90, p < .01; r = -.56 with GAF, *ns*; r = .83 with cortisol, p < .05).

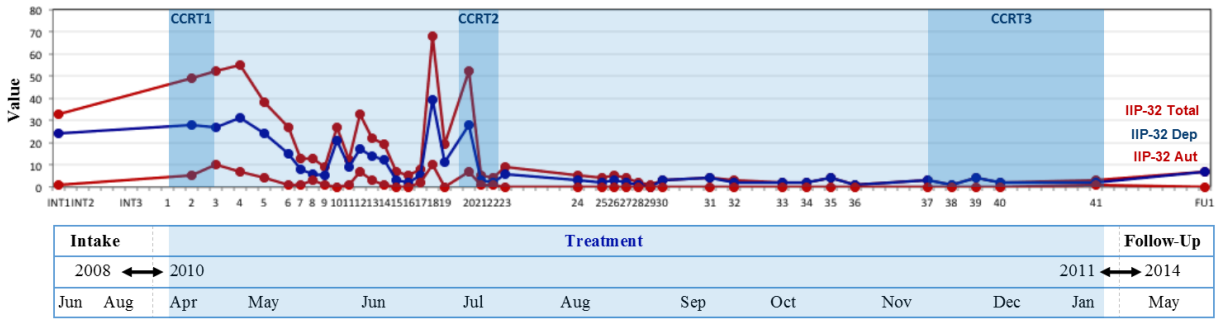

Figure 3. Evolutions in patient-reported interpersonal problems from intake to follow-up. IIP-32 Total = Inventory of Interpersonal Problems-32 total scores; IIP-32 Dep = Inventory of Interpersonal Problems-32 subscores dependency; IIP-32 Aut = Inventory of Interpersonal Problems-32 subscores autonomy; CCRT1 = Conflictual Relationship Theme codings of first three sessions; CCRT2 = Conflictual Relationship Theme codings of Tipping point sessions; CCRT3 = Conflictual Relationship Theme codings of last five sessions.

Qualitative Description of Association. *Preliminary note*: in referral to Luborsky's (1984) manual of supportive-expressive therapy, concrete therapeutic interventions are italicized, and designated as 'expressive technique' (ET) or 'supportive technique' (ST), including the related manual page. Literal wordings of patient and therapist are indicated by double quotation marks ("…")

Context. James entered therapy in intense confusion and distress. As outlined in Step 1, he had first been referred for individual treatment by the relational therapist he and his girlfriend Rebecca had been consulting for over a year; mainly to work on three issues that impeded their relational happiness, i.e.: frequent arguments (including verbally aggressive "outbursts" from his side); often "not knowing what to say to each other"; and Rebecca's "complete absence of sexual desire". Just as the quality of their relationship had "finally improved a bit," James' first dissociative episode had taken place. *Incited by the therapist (ST, p.87)*, James specified how Rebecca had brought him face to face with sexually explicit chats with another woman she had discovered on his computer, which made clear he had met and slept with her in real life as well. Though the evidence was indisputable, James had initially been unable to recognize himself in the chats, because of (1) the "vulgar tone" of the chats (i.e., containing "words I would never use", "not how I usually speak"), which had literally disgusted him so much he had to vomit the first time he was brought face to face with it; because of (2) the object choice (i.e., "absolutely not the type I am habitually attracted to": disheveled, unemployed, low-class, smoking and drinking during her pregnancy), as the complete opposite of the beautiful and respectable Rebecca; and ultimately because (3) "I have a completely different story in my head of what happened that night" (i.e., a birthday drink with a colleague). Secondly, Rebecca had confronted him with credit card bills of expensive, "luxurious" computer parts he had "not actually needed" at the time, whilst being "utmost convinced" he had "exchanged" them for other parts (with a friend). Consequently dreading he "might have been doing all sorts of other things without knowing about it", he had consented to individual therapy. As noted in Step 1, he had quit after three sessions, after which a second dissociative episode (i.e., 1 years and 7 months later) had prompted him to re-enter into therapy. Suspicious of James' late restlessness and migraine attacks, Rebecca had again found

chats with the same woman, and had tearfully ended their relationship. Driven by despair, intense confusion (feeling he had moved from driver to passenger seat, e.g., “Apparently I am no longer in control of what I do or don’t do”, “I cannot even trust myself anymore”, “Who knows what else I might have been doing or might do in the future”), and immense fright he would uncontrollably “keep dissociating”, James had voluntarily contacted the same therapist by e-mail (as “he had been the first one who had *allowed me to speak about what truly mattered to me*”, *ST, p.82, 83*), explicitly marking in boldface the question “Will I ever get rid of it or is it a condition I will carry with me for the rest of my life?”. *Inspired with hope*, however, *by the therapist’s assurance (ST, p.83)* that psychotherapy yields the possibility of symptom reduction, even disappearance, on the condition he was willing to apply himself to therapeutic work, James’ suicidal ideas eased and he eagerly started therapy.

Therapeutic Process. During the intake sessions, the therapist mainly *asked James to concretize and elaborate on his disclosures (ST, p.87, p.89)*. As such, James also explained about troubles concerning longstanding “gaps” in his memory of childhood events prior to the age of fifteen years. *Asked to expand on this subject (ST, p.87, p.89)*, he immediately linked these gaps to “early incidents at home” he had “repressed”, words he had borrowed from textbooks when he had studied remedial education. Based on a few, vivid memories of seeing his older brother being harshly punished by his “physically aggressive father”, school psychologists (i.e., during secondary school) had suggested that the voids in James’ memory had probably been due to “abuse” (i.e., being abused himself); which had soon become a burning mystery that troubled him to date and still hampered him in current contact with his father. James painfully disclosed he had “never really known why my brother had been punished so harshly by my father,” the reasons for which had always been kept quiet for him by his strict, short-spoken father. “Feelings or emotional stuff” had never been discussed in his secretive family. His mother (who worshipped his father) had always turned a blind eye and had shrugged off her children’s retorts of indignation in defense of her husband, by airily justifying that “he must have had his reasons”. To fill this lack of explanation, James had ascribed these cruel punishments to his brother’s disappointing school results. *Interrupted then by the therapist in order to clarify the reason for having consulted psychologists during his school career (ST, p.87, p.89; ET, p.114)*, James divulged about his own poor school results during secondary school, greatly contrasted by his often-excellent performance during lessons. Here, too, he had never understood the origins of this “fear of failure” that had always made him freeze during tests; i.e., a second mystery that still preoccupied him.

As the therapist next picked up on the newly raised theme (ET, p.94, p.97, p.114; ST, p.87, p.89) of aggression during former fights with Rebecca, and *inquired after determinants for James’ behavior (ST, p.87; ET, p.114, p.131)*, while *marking the contrast* with a series of previous examples that revealed his overall compliant nature towards others *(ET, p.110, p.114, p.121)*, James disclosed about deep-rooted feelings of “being a failure” and “not being good enough”. He claimed these feelings to be rooted in former parental reactions of harsh rejection, and triggered by Rebecca’s remarks on his housekeeping abilities. When the subject next landed on Rebecca’s longstanding

absence of sexual desire, and the according deprivation of sexual activity between them, the therapist *inquired whether this had also incited anger or frustration in him (ET, p.94, p.114)*. James replied halfheartedly that he had "wanted to be angry, but couldn't," as "she had not behaved like that on purpose" (i.e., Based on previous issues with her father "she couldn't really help it"). *As the therapist suggested that (ET, p.114, p.121; ST, p.82)* "unexpressed anger often finds another way out", James assented and immediately added a second reason that had motivated him to refrain his anger, i.e., "out of fear that she would otherwise leave me".

In the first therapy session, the therapist *explained the therapy rationale, described neurotic symptoms as often representing "elements that are warded off within a subject's relational life",* and accordingly *invited James to voice everything that comes to mind during sessions, in assuring that symptomatic alterations would ensue (ST, p.63, p.82, p.83; ET, p.94).* Notably, from the second session onwards, James soon abandoned the focus on past dissociations and eagerly launched into discussion of a variety of distressing relational issues and residing inner experiences. Up to session 20, central topics of discussion were his feelings of loneliness, abandonment and frustration with Rebecca's distant reactions after they had split up, "despite her initial consent with keeping in touch". His "whole world turned around Rebecca" and all his efforts were guided towards "regaining her trust" and "getting her back", wishing he could undo his mistakes. The therapist *mainly took on a supportive, encouraging stance by paraphrasing (e.g., equipping James with words to better define what he went through; ET, p.107, p.114, p.118; ST, p.89), by regularly interrupting James' repetitive moans with incitements to specifically illustrate and contextualize his remarks (ET, p.94, p.131), in order to elucidate determining longings and desired reactions, and by linking related pronunciations to illuminate potential patterns and dissimilarities across relationships (ET, p.94, p.118, p.131; ST, p.89).*

Whereas James initially coupled his second dissociative episode to "distress" following a car accident in the preceding week, *therapeutic incentives to illuminate the surrounding context (ET, p.121; session 1)* revealed how the dissociation had taken place "during the period Rebecca had increasingly started to go out, in the company of other men, leaving me all alone at the house". Whenever he had prudently tried to discuss his resulting frustrations with her, he had hit a solid wall, however. *Asked about his parents' habitual openness to discussion (ET, p.110, p.118; session 2)*, James reminisced regular aggressive outbursts towards his parents, as his "father's word had always been the law" ("without any room for discussion"), and his mother had always obeyed the latter in admiration, without ever sticking up for her children. "The only thing I was ever allowed to do at home, was to follow orders, which I did, but with a head that boiled with suppressed rage". *When the therapist pointed to the marked contrast (ET, p.110, p.114, p.121)* with James' previously recited examples of satisfying interactions with (other authority figures like) his boss and colleagues, James underscored that "they truly appreciate me", "for them, I am not just a number, which is the main reason I continue working there, as the job contents itself is not all that stimulating". *The therapist subsequently underlined his profound wish* to be of value and important to others *(ET, p.110, p.118, p.131; ST, p.89*).

James entered session 6 with the statement he had suddenly remembered he had dissociated before, i.e., during the relationship with his ex-girlfriend Patricia. He explained she, as well, had found chats with another woman he had not immediately recalled (though not sexually explicit and without actual adultery), and "had spent money like water at the time", which had incited Patricia to closely monitor his financial expenses. *As the therapist pointed to the similarity with James' descriptions of Rebecca's financially restraining behavior,* and further *inquired whether his parents used to control his expenses (ET, p.94, p.118, p.131; ST, p.89),* James revealed he had "always bought stuff behind their back" as his (wealthy) parents had always lived frugally and had never approved of "buying things you don't actually need" or "luxury". Frustrated, James had never been allowed to perform a students job during the summer holidays, but had instead been obliged to do chores at home, for which he had never received payment. Consequently, James had never had any money to accompany his friends in pleasurable activities. Even with respect to "what they knew to truly and deeply interest me" (i.e., computers and accessories) he had always received second-hand objects, "after my father had been done with them". *Encouraged by the therapist to expound on this theme of restriction (ST, p.87, p.89; ET, p.94),* James continued that sexuality, as well, had been under (extreme) taboo. Talking about it "had completely been out of the question", and the television screen had always been hastily covered up each time a sexual interaction ("so much as a little kiss") had been displayed. Upon finding a love letter in James' bedroom, his mother had furiously "acted as though I started World War III!". *As the therapist punctuated the tight financial and sexual restrictions, installed by his parents and former partners as a common denominator* in James' recited examples (*ET, p.110, p.118, p.131; ST, p.89)*, James acknowledged interestedly. Upon *further inquiry into his habitual reactions to this restricting behavior (ET, p.110, p.118;* session 7), James admitted his repeated "refusal to simply obey their rules", "since they would have taken that for granted". He continued that "meanwhile, this experience of injustice against me has shifted towards other people who are treated unjustly", in particular handicapped persons, for whom he had long desired to make a stance (motivating his former choice to study remedial education). *Egged on to elaborate on this subject (ST, p.87, p.89; ET, p.94)*, he recalled a few vivid memories of particular incidents during grade and secondary school, which *the therapist picked up to contrast with James' previous complaints about "having no recollection of childhood events prior to the age of fifteen" (ET, p.110, p.118; ST, p.89)*.

In session 11, James stated in wonder that singular memories "I used to have no recollection of whatsoever" were "suddenly coming back", stimulated by renewed contacts with old friends (In other words: besides therapeutic work during sessions, James also applied himself diligently to the effort of 'working through' between sessions). *Asked to concretize (ST, p.87, p.89; ET, p.94)*, he recalled online conversations with a female friend to whom he had "spoken ill of Rebecca" during the period she had stubbornly deprived him of sexual interaction. Stressing his experience of a *supportive alliance*, he pronounced himself pleased with "the progress *we* have made thus far" and reported increasingly less fears of being subject to lifelong dissociations. (Notice how this is reflected in his best score since the onset of treatment on GHQ-12, SCL-90, GAF, IIP-32; see Figures 1, 3).

The ameliorated state, however, plunged in session 12. During the preceding week, James had found out Rebecca had already engaged in a new romantic relationship ("without informing me about it"), which re-ignited suicidal ideas and "continuous crying fits" over failing efforts to get her back. *The therapist mainly assumed a supportive stance, encouraged James "to talk through" his grief (ST, p.87, p.89)* during sessions 12-19, and *explicitly directed him to contextualize his remarks (ET, p.94, p.131)*. *He further explained that* "shedding more light on and defining more clearly the wishes, needs and desired reactions that have been frustrated in relationships thus far", would allow him "to better live up to them in new relationships".

From session 13 to 19, James' state ameliorated again and his hopes lifted (see steadily decreasing ill-being scores in Figures 1 and 3, in contrast to the preceding fluctuating movements between intake and session 12): he reinstalled friendships he had neglected while being with Rebecca, started to take care of himself again, and flirted with the idea of resuming his studies in remedial education. "Since secondary school, I have always had a sort of unreal feeling, and never understood why I was feeling unwell. I could not care less about my future, unless other people were involved. For the first time, however, I'm driven to actually make something of my life" (session 14). *Upon the therapist's appraisal of these therapeutic gains (ST, p.86)*, James continued to "feel capable of making a new start, not because of the break with Rebecca, but because of this therapy, since a lot of things that intensely affected me in my past seem to be related to the cause of my dissociations".

Over the next weeks, increasingly enjoyable contacts with his former "soul mate" progressively enlightened for James the disappointment and negativity that entailed (past and current) interactions with Rebecca. *Repeatedly incited by the therapist to closely compare both types of interactions (ET, p.94, p.131)*, James described how Holly truly was his "female counter part", how they seemed to "understand each other without words", how "everything felt much more genuine with her" and how this increasingly roused unprecedented feelings of inner calm and joy that radiated upon other social contacts as well. Both at work and during leisure time, "I still want to help others in any way that I can, yet, no longer at the expense of my own well-being". In session 15, he declared (in a notable calmer fashion than before) that his "second dissociative episode had probably been triggered by the dawning feeling that our relationship was drawing to a close anyway". Increasingly acknowledging the dissociations as reactions to things that had already (i.e., prior to onset of dissociations) been malfunctioning for a while in his relationship (instead of being the other way around), he stated: "Rebecca had started going out again with numerous male friends. The dissociation is not – as I used to think – connected to the car accident, but to the indignation and impotent rage I felt seeing her behavior". *In explaining how symptoms are usually determined by multiple factors, the therapist invited James to continue talking during therapy in order to consolidate the therapeutic gains (ST, p.87, p.89; ET, p.114). Next, drawing attention to James' recurrently declared desire to help others, he prudently suggested a link with James' father's profession of physician (ET, p.94, p.98, p.114; ST, p.89)*. James replied in assent that he had "always been very proud of and respectful for" his father's professional

activities, yet observed a significant difference between the two of them: “my father physically cared for the disabled, but was emotionally very cool, while I embody the opposite”. Cracks had started to appear, however, in the longstanding image of his father as the inscrutable “bogyman”, for James had recently got wind of “my father’s own brutal upbringing” that had “not set a good example to him”, and made “a reasonable explanation – though not excuse – for why he ruled us with an iron hand”. In addition to James’ earlier descriptions of interpersonal shifts towards discussing matters more frequently and openly with others (see session 11), James narrated how his hitherto secretive mother had started “to increasingly approach me increasingly as an adult” (i.e., “confiding more in me”) and how his father had become more accessible “with old age”.

In session 18, however, James arrived “deeply confused”. He felt torn between unprecedented, slightly unsettling experiences of energy and joy, on the one hand (e.g., “I am profoundly changing in a most positive way, both inwardly and towards others”, “it is a completely different kind of feeling good”), and unclear feelings of guilt and remorse, on the other. The fact that “Rebecca had engaged in a new – sexual (!) – relationship so soon” still upset him. *After repeatedly inciting James to bring his experiences into speech and helping him to find the right words (ST, p.87, p.89; ET, p.94), the therapist prudently identified determinants of James’ internal conflict:* guilt towards Rebecca for thoroughly enjoying himself, and simultaneous anger because she herself was having a good time with someone else. Incensed that “she had moved on so lightheartedly”, James endorsed *the therapist’s subsequent reformulation* (*ET, p.107, p.114, p.118; ST, p.89)* of “feeling resentful towards Rebecca because you are feeling guilty about having a good time while she shows no sign of guilt whatsoever”. Frustrated, James repeated how he “wanted to be angry with her, but could not”. *Stimulated to resume narration on this theme (ST, p.87, p.89; ET, p.94, p.131)*, he clarified a number of reasons, i.e., “because I still love her most deeply”; because “I cannot call her to account, as it is my own fault that she left, seeing that I was the one who cheated on her”, and “out of fear she would push me out of her life completely”. *At the therapist’s further request to describe this fear (ST, p.87, p.89; ET, p.94, p.131)*, James named his “difficulties in expressing anger towards others” as a longstanding, recurring theme across relations, “as I am always frightened they will get angry as well, and will subsequently push me out”. He ended the session expressing his “immense relief with having been able to place all these mixed-up feelings” (echoed in improved well-being scores in session 19, see Figures 1 and 3).

During the week preceding session 20, however, James’ mother informed the therapist that James had made a suicide attempt, and currently resided in the hospital to recover from an overdose of tranquilizers. Thereupon, *the therapist phoned the patient at the hospital (ST, p.82)*, experienced by James as “immensely beneficent”. *Repeatedly incited James to precisely describe the thoughts and feelings that had provoked his act (ET, p.97, p.110, p.114; ST, p.87;* session 20*)*. James explained how Rebecca had failed to call him after the last session, how she had retorted his indignant reprimand by sending him the text message “you are not the most important person in my life right now”. The feeling of “no longer meaning anything to her” had made him so outraged and despaired he

had attempted to take his life and, thereby, to induce her with guilt. After the initial disappointment of having been unsuccessful, however, "things had changed completely when Holly and my mother arrived", who had lovingly stayed by his side ever since. The worried and loving reactions of his parents, colleagues and boss had made him "so glad the suicide attempt had failed" and accordingly "turn the corner", as "I suddenly realized there really are people that care for me". *Upon the therapist's suggestion that anger might have played a vital role in the origins of his dissociations, as well (ET, p.114, p.121; ST, p.82),* James contradicted: "I rather felt disappointed. The first time, because Rebecca would never give me any chance to please her [sexually], the second time because she was already feasting her eyes on someone else". *After replying that disappointment might indeed have acted at the conscious surface, but that suppressed feelings of anger might have manifested in the actual dissociations, the therapist prudently shared his impression (based on previous remarks; ET, p.94, p.97, p.114)* that James habitually set himself stringent norms concerning anger and (overt) aggression. Upon James' prompt exclamation "I do not want to be like my father!", *the therapist continued that this refusal might have been the obstruction to allow his own anger, which subsequently manifested in the dissociations (ET, p.94, p.97, p.114).*

Notably, from session 21 onwards, James recurrently described feelings of inner calm, energy, balance and being loved (clearly reflected in stable, low ill-being scores in Figures 1 and 3) and expressed he had engaged in a romantic relationship with Holly. *Tying these disclosures up with the anger discussed in session 20 (ET, p.94, p.97, p.114; ST, p.87, p.89), the therapist recognized that "something had changed in your aggression regulation"* (i.e., aggressive impulses had become more tolerable). James assented by recounting a recent incidence in which his father had angrily stormed out of the house. "For the first time ever, I had recognized myself in him. Now it is obvious where I got it from. I always said I did not want to be like my father, but apparently I already was". He continued by reminiscing a (suddenly arisen) memory of his father calling him "a wrapped up piece of shit" at the age of fifteen years, which "had always had a great impact on the rest of my life". *Further egged on (ST, p.87, p.89; ET, p.114),* he proceeded by recalling numerous memories of his brother being punished by their father. He described how memories "of my past" had gradually started to come back (i.e., images of how his parental home and grade school had looked like). In reply to *the therapist's referral to previous remarks of James' mother's recent assumption of a more open stance towards him (ET, p.94, p.118; ST, p.89*; see session 15), James narrated how (upon persistent incitement from his side, in marked contrast to his former defeated stance towards her secretiveness) she had recently revealed a crucial piece of information to him concerning the reason for these punishments. It turned out his brother's depressing school results had been "the expression of his maladaptive life pattern, which consisted of drugs and male prostitution", and "that was why they punished him and restricted me in going out with friends". The acknowledgment of "the impotence my father must have felt seeing this maladaptive behavior of one of his sons, for whom he had big plans" had steadily lessened his initial indignation and perplexity, and made him see the hard-handed parenting principles in a new light. *Upon referral to James' earlier phrasings concerning "feelings of injustice" and "desires to rise against it" (ET, p.94, p.118; ST, p.89;* see session 7), James disclosed in session 23 about the anger

he had felt as a child seeing “the unjust treatment” of the brother he had cared for. “For he had been the one who had looked after me and nurtured me, as my parents had rarely been at home”. This information had also shed new light on “the origins of my own poor test results, despite excellent performance during classes”. James stated: “I never fully understood the reasons for my anxiety, but now I realize I used to link poor outcomes to disproportional punishments, which put so much pressure on me, I blocked”.

Throughout the rest of the therapy (sessions 24-41), James mainly resumed illustrations of past, disappointing interactions with Rebecca, to contrast with current, enjoyable exchanges with Holly, old friends and his parents. He had disentangled from former, desperate attempts to gain Rebecca’s love, as from pondering over troublesome mysteries in his past. While James reflected upon the changes that increasingly colored his life since his failed suicide attempt, *the therapist mainly assumed a supportive, incentive stance, helping to define general remarks more precisely, appraising therapeutic gains, pointing to recurring patterns or significant distinctions and helping James to integrate all discussed elements in a coherent, meaningful ‘story’ (ST, p.87, p.89; ET, p.94, p.114).* In session 25, James admitted to “no longer ponder over the dissociations” and appended that “they were related to financial and sexual issues, which were precisely the points at which Rebecca was very restrictive, without any room for discussion. Rebecca had always been very dominant and controlling”. In addition to Holly’s apparent enjoyment of his efforts to care for her (emotionally) and please her (sexually), the thing James most appreciated about her is “the ability to talk openly about everything, which is the principal strength of our relationship. I have nothing to hide for her”. This resulted in augmenting confidence that dissociations would not reoccur in his current, satisfying relationship. *Upon the therapist’s inquiry after other past relationships (ET, p.94, p.131)*, James clarified how his former partners “had always made all the decisions, without me having a say in it. I just followed them,” while adding he had also “looked for it, as I used to be scared to make decisions myself”. “On the other side, I suppressed my resulting frustrations and inevitably exploded at some point”. *As the therapist appraised James’ recognition of a pattern across past relationships with his parents and ex-girlfriends (concerning financially and sexually restrictive, controlling and secretive behavior), and further underlined the sharp contrast with his current relationship with Holly (ET, p.110, p.114, p.121)*, James continued in assent that “Holly and I grant each other independence, while simultaneously enjoying a lot of activities together and talking openly about it. Everything feels much less forced and restrained”. Then, *inquired after his former experiences during couple therapy (ST, p.87, p.89)*, James explained how he had been imposed to “learn strategies to better comply with each others’ needs” and (“now I come to think of it”) how this had fanned the flames of (bottled-up) rage even more. Rebecca had started to consent to sexual contact, but “with such distaste, it had felt like rape”. For him, wishes to please her, and enjoy these contacts together, had always prevailed upon mere satisfaction of erotic longings. The first dissociative episode had indeed occurred soon after.

In sessions 28-29, James extensively resumed descriptions of past interactions with his parents. He explicitly described how his mother had always “concocted stories” to conceal “what took

place indoors" (i.e., "my brother being on the wrong track") from both family outsiders as her own children. "It is apparent where I got my own secretiveness and concealment from," he stated. *Recurrently incited to resume narration about the concealed incidents at his parental home (ST, p.87, p.89; ET, p.114)* James revealed for the first time how he had recently stopped having nightmares during which he assumed a fetal position; which had always puzzled him, but now reminded him of a vivid image of his brother lying at the foot of the stairs in a fetal position, after being punished very harshly by their father. "That had been the only time ever she had hold my father back".

In session 31, James happily exclaimed he had successfully passed an important exam that offered new possibilities at work. Anew reflecting upon his breakup with Rebecca, he peacefully expressed in session 35 how his breakup with Rebecca now left him with positive feelings, "I can't call it a failed relationship, because, if I had not had my relationship with Rebecca, things would be much more difficult with Holly. And Holly truly is the right person for me. Rebecca and I just did not fit. I'm pleased with how things have turned out".

During the last sessions, James confessed he no longer knew what to talk about, "everything was falling into place" and recited that "the dissociations had occurred for a reason", that "I used to have a hard time accepting what has happened", but he now felt more peaceful towards it. After session 41, a new appointment was scheduled, but he did not return to therapy.

During the follow-up interview, James affirmed maintenance of the cited gains, reported professional satisfaction, happily narrated about Holly, their house and lovely children. He added laughingly that they annually joined his parents to spend the summer holidays together, and how he "would have never dreamed it possible before". He claimed to be "very grateful" towards the therapist, whom he had always experienced as very supportive.

General Discussion and Conclusion

The present study started from the longstanding controversy in present-day literature on the veracity of the diagnosis 'Dissociative Identity Disorder' (DID; DSM-V, APA, 2013). Following a structural, psychodynamic approach of addressing *dissociations* as *hysterical symptoms*, and further building on the symptom specificity hypothesis (Blatt, 1974, 2004), which typically links hysterical symptoms to a *dependent* (rather than autonomous) interpersonal style, this paper presented an empirical case study of the successful treatment of a patient suffering from dissociations. In consideration of previous, conflicting findings on symptom specificity (for which several conceptual and methodological claims have been raised; see Cornelis et al., 2016), the current case study applied a research methodology previously developed by Cornelis et al. (2016), in an effort to enhance further understanding of symptom specificity, in general, and dissociative symptoms, in particular. Aiming to detect areas where the classical hypothesis potentially needs to be *refined* (i.e., when applied to longitudinal, clinical case data), the study thus intended to contribute to *theory building* (Stiles, 2009) in a *clinically meaningful* way (Dattilio, Edwards, & Bromley, 2004).

In line with expectations based on the classical symptom specificity hypothesis, both (high and significant) longitudinal intra-subject correlations, and extended qualitative analyses of the narrative material, affirmed *close associations* between the patient's symptomatic and interpersonal functioning. In this patient, DID did not manifest in so-called 'alters' or split sub-identities (e.g., Verhaeghe, 2004), but referred to the occurrence of two delimited, past (and anxiously anticipated future) dissociative episodes, during which the patient had displayed singular behavior he did not recall afterwards. At the onset of treatment, dissociations clearly proved to be embedded in the patient's current way of relating to his then girlfriend: (1) *she* had been the one who had '*uncovered'* the dissociations, (2) during which he had exhibited *sexually explicit* behavior, (3) taken place throughout the course of couple therapy, (3a) which they had attended for *her absence of erotic longings* (amongst other reasons), and (3b) which had occurred right at the moment the quality of their *relationship* had (seemingly) *improved*. Despite these linkages, however, the patient experienced these past dissociations at the start of treatment as isolated events that greatly disrupted his sense of a unitary self. Yet, throughout the course of therapy, it progressively became clear he had temporarily disintegrated *specific* psychic material from conscious awareness, particularly pertaining to *sexual* and *financial* contents, which related to *long-misrecognized urges*. The patient's difficulties – even impossibility – to assume these urges gradually proved to be due to his own strict moral standards (especially concerning sexuality), and stringent *restrictions* imposed by significant others, whose love and approval were essential to his sense of self-worth. In marked contrast to the latters' habitual *taciturnity* (even taboo) concerning these specific subjects, the therapist's repeated incitements to *voice* them during therapy, progressively illuminated the dissociations as (typically hysterical) '*compromise formations'* (Freud, 1900/1978; see also Blatt, 2008, p.177) to (1) maintain predominantly strived for (and, in casu, already delicate) *interpersonal harmony*, whilst (2) simultaneously gaining *satisfaction* for *unfulfilled needs* that threaten to disturb this harmony (particularly long-contained erotic longings towards his overly frigid partner), and (3) *manifesting* long-suppressed feelings of *resentment* towards his partner's and parents' lighthearted manner of assuming obedience to their rules (especially to their financial and sexual restrictions). Via the therapist's recurrent efforts to engage the patient in reflecting on and voicing (frustrated) longings, the latter began to experience his past dissociations increasingly less as events that had passively and uncontrollably occurred to him, but as *meaningful reactions* (i.e., of formerly unrecognized, but essential parts of his own subjectivity) to things that had been malfunctioning for a long time in current and past relationships. As such, a *pattern* became clear in his object choices and his habitual relational stances towards them. In line with expectations and consistent with findings from earlier studies (e.g., Cornelis et al., 2016; Cornelis et al., under review: Grenyer & Luborsky, 1996; Luborsky & Crits-Christoph, 1998; Slonim, Shefler, Gvirsman, & Tishby, 2011), the resulting insight progressively incited the patient to occupy *different interpersonal positions*, and to live up to his wishes in unprecedented *non-symptomatic* ways. In the course of this process, he also began to relate longstanding memory 'gaps' to *selective* amnesia of particularly *painful* childhood events, whose *disengagement* from clear attributions incited intense anxiety (see also Merskey, 1995, p.328). Hence, the patient's and therapist's joint efforts to organize the (initially isolated) dissociations

in meaningful, symbolic frameworks (see also Angus & Kagan, 2013) eventually inclined the patient to come into terms with their underlying determinants, and curtailed anticipatory fears concerning future dissociative episodes.

Importantly, the present case study draws attention to the clinical importance in treating patients with DID of *giving free rein* to the entire scope of patients' *subjectivity*, in its various – and often conflicting, but just as much essential – facets. A supportive therapeutic stance (see Luborsky, 1984) of acknowledging the patient as an *essentially divided subject,* including aggressive and sexual impulses the patient is often ashamed of (e.g., Verhaeghe, 2004), and helping him/her to *voice* the experiences and urges that could not be assumed before, allows the patient to *reintegrate* warded off material into his/her broader subjective functioning. As formerly blocked psychic material progressively re-circulates within (newly constructed) meaningful frameworks, its frightening load diminishes, and clenched energy comes free to reinvest in other ventures (see patient's disclosures about "inner calm", "energy", "balance", and "spontaneity"). Whereas this holds in essence for all hysterical (and, in general, neurotic) symptoms, it pre-eminently pertains to dissociative phenomena, which can be viewed as 'exaggerated' endeavors of disintegrating rejected material from the ruling stream of conscious awareness. Tackling the symptom directly (as is common in mainstream health care) or 'cooperating' with the patient's 'good' ego in finding more adaptive (i.e., less symptomatic) ways to defend against 'undesired' or anxiety provoking impulses (or identity layers or alters) entails the danger of reinforcing the patient in his current tendency of misrecognizing these essential parts of his subject-being. For the current patient, this could be seen in his disclosures about previous couple therapy, during which he and his partner had learned strategies to conform more adaptively to each others' needs, while the structural determinants for their relational behavior remained (once again) untouched; which eventually culminated, for this patient, in his first dissociative episode (in marked contrast to the relief he felt by "finally being allowed to speak about what truly matters to me" with the current therapist).

However, in this process of re-integrating rejected material into subjectivity, the question of whether or not these 'recalled memories' are '*true'* (i.e., actually happened), seems, from a *clinical* point of view, *off-topic* (see also Merskey, 1995, p.329). The main therapy goal should not be to recover 'lost' memories into the presumed 'unitary' self of yesteryear, but to allow the subject to construct new (i.e., less 'forced'/symptomatic, more flexible/'freely chosen') means of functioning (i.e., not 'Is it *true*?', but 'Is it *effective*?'). In this respect, clinicians should also be prudent with relating certain (possibly imaginative) disclosures of the patient to specific presumptions concerning childhood trauma(ta). For the current patient, we refer to the suggestion of (verbal and physical, possibly sexual) 'abuse' made by former school psychologists that had started to lead a life of its own, and had subsequently hampered the patient in ongoing contacts with his father (see also 'false memory syndrom', e.g., Merskey, 1995, p.329; Verhaeghe, 2004)

Whilst the previous empirical case studies on symptom specificity with obsessional patients reported higher complexity than assumed by the classical hypothesis (see Cornelis et al., 2016; Cornelis et al., under review), quantitative analysis of self-reported interpersonal problems in the current patient documented the predicted *dependent* interpersonal profile. Accordingly, CCRT-analyses revealed the predicted predominance of *dependent* components (Luborsky & Crits-Christoph, 1998) across relationships with significant others and the other in general.

Throughout treatment, the patient's CCRT did not change substantially, yet, heightened awareness of his wishes (as recurrently mobilized by explicit therapeutic incitements to reflect on frustrated longings in past disappointing relationships) entailed more flexible ways of living up to them, both in establishing new relationships as in asserting his wishes within these relationships. Consistent with previous findings (e.g., Cornelis et al. 2016; Cornelis et al., under review; Crits-Christoph & Luborsky, 1990; Vinnars, Dixon, & Barber, 2013; Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004), this process encompassed a significant increase in positive responses from others and self. Further in line with expectations, these interpersonal changes were accompanied by alterations in (coping with past and anticipated) dissociations and transformations in broader symptomatic and general well-being, as previously evidenced by, e.g., Cornelis et al. (2016), Cornelis et al. (under review), Crits-Christoph & Luborsky (1998), Grenyer & Luborsky (1996), and Slonim, Shefler, Gvirsman, and Tishby (2011).

In accordance with findings from large-scale studies on the efficacy of psychodynamic therapy (for recent reviews, see Fonagy, 2015, and Leichsenring et al., 2015), outcome scores and the patient's narratives demonstrated significant improvements during therapy relating to symptomatic, general and interpersonal well-being, which were maintained at follow-up.

Here proves the added value of triangulating quantitative outcome data with qualitative data-analyses (e.g., Jackson, Chui, & Hill, 2011; McLeod, 2013). Solely aiming at symptom reduction, and basing clinical judgment upon the stable period depicted in the quantitative graphs from session 20 onwards (demonstrating maintenance of therapeutic progression), one might assume further treatment to be redundant. However, important processes took place during that period, which were necessary to 'consolidate' gained progression. The energy that was from then onwards 'disentangled' from symptomatic investment and (compulsory) repetition of interpersonal patterns, came free to engage in endeavors of 'working through' relational conflicts, and 're-writing' initially enigmatic experiences within ongoing meaningful constructions (e.g., Verhaeghe, 2004).

Limitations and Future Research Indications

In an effort to enhance a rich understanding of symptom specificity concerning DID symptoms, in particular, and hysterical symptoms, more general, the present study targeted at addressing several methodological limitations intrinsic to statistical hypothesis-testing research in cross-sectional group

designs. Accordingly, however, restrictions apply in statistical generalizability of the findings to broader populations of DID – and hysterical – patients. Therefore, it would be valuable to contrast our results to findings from future longitudinal (single/multiple) case studies of similarly diagnosed patients (from equivalent and alternative therapy schools), as to whether (dis)similar patterns can be found in the underlying processes that led up to the discussed symptomatic and interpersonal alterations (see also Iwakabe & Gazzola, 2009).

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5

EMPIRICAL CASE STUDY 4

INTERACTIONS BETWEEN HYSTERICAL SYMPTOMS AND INTERPERSONAL DYNAMICS THROUGHOUT PSYCHODYNAMIC PSYCHOTHERAPY:

A CASE OF CONVERSION DISORDER

Since its first description by Freud, conversion disorder has appeared under a variety of miscellaneous terms in present-day literature and remains to date a contested diagnosis with uncertain aetiology. In structural psychodynamic diagnostics, conversion is generally considered as a typically hysterical symptom, and consequently predicted by the symptom specificity hypothesis (Blatt, 1974, 2004) to be primarily associated with dependent interpersonal functioning.

However, cross-sectional group studies have yielded mixed results on symptom specificity. In addition, preceding empirical case research has reported higher complexity than originally assumed by the classical symptom specificity hypothesis in case of obsessional pathology (Chapters 2 – 3), but not in case of hysterical pathology (Chapter 4).

The present empirical case study aims to contribute to theory building through further exploration of clinical complexity in the supportive-expressive treatment of a patient suffering from conversion disorder. In accordance with previous case studies (Chapters 2 – 4), Consensual Qualitative Research for Case studies is applied to quantitatively-qualitatively investigate longitudinal clinical interplays between symptomatic and interpersonal evolutions throughout therapy.

In line with the first case study on hysterical pathology (Chapter 3), findings demonstrate that symptoms are embedded within weighty dependent conflicts. Dissimilarly, however, additional diverging elements are observed, which cannot be easily reconciled with the classical conceptualization of symptom specificity, yet, which accord to broader psychodynamic notions of structurally underlying dynamics. Again, conceptual and methodological considerations are addressed; and limitations and future research indications are advanced.

Introduction

The psyche-soma dualism constitutes one of the oldest topics on the scientific agenda. Ever since Plato mused on this anthropological issue, the body-mind division has had a profound impact on Western thinking and the organization of health care study and practice. To date, medical and psychological disciplines continue to distinguish their respective study domains and clinical practices. However, physical complaints that are not readily attributable to conventionally defined diseases have long been reported in scientific writings. One of the first authors to extensively elaborate on psychic dynamics operating in overt somatic expressions was Freud, i.e., in his study of so-called 'conversion hysteria' (e.g., Breuer & Freud, 1955 [1895]). Since Freud, scientific literature has been scattered with similar reports appearing under a variety of different names, e.g., medically unexplained -, functional somatic -, psychosomatic -, somatization -, conversion -, somatoform -, complex somatic -, symbolic symptoms/syndroms/disorders/reactions. In spite of the high prevalence of these contested phenomena in health care vicinities, present-day literature is still characterized by diagnostic controversy. Much remains uncertain about aetiological factors, making patients presenting with these phenomena challenging to treat.

Essentially contributing to this diagnostic and aetiological confusion is the currently predominating *descriptive* approach to (psycho)diagnostics. For the diagnostic focus on the *phenomenological* expressions of – and the *common* predisposing factors in – conversion disorder threatens to obscure the underlying *structural* dynamics of these typically heterogeneous manifestations. As the frequently used term '*functional* somatic symptoms' implies, these phenomena often appear to serve a function (or most often: multiple functions) within the subject's broader *social* world, with which they prove to be intrinsically interwoven. Broom, Booth and Schubert (2012, p. 16) describe an "unbroken continuity between internal body processes and external interpersonal meanings and influences", implying that both are crucial to disease developments. Diseases arise in *persons*, and thus in a context of subjectivity, experience, meaning, history, exchange and narration. Given the "co-emergence" of bodily and symbolic processes in human existence, many physical manifestations present with profound meanings, which are consequently an *integral part* of their presentation. Given that the body would contain the life story just as much as the brain (Edna O'Brien in Roth, 2001), and somatic symptoms have been documented to embody corporal metaphors (e.g., Benoit & Cathébras, 1993), it appears quintessential to incorporate the subject's singular relation to his/her body in the diagnosis and treatment of physical manifestations.

In contrast to the prevailing medical current, which starts with the idea of illness and then proceeds to 'look' for determining factors, psychodynamic diagnostics (e.g., Vanheule, 2014; Verhaeghe, 2004) centralizes the ill subject and 'listens' to his/her narrations in order to grasp the perceived circumstances in which the symptoms emerged and evolved. From a *structural*,

psychodynamic point of view, (bodily/psychic) symptoms are not envisioned as detached units that 'happen' to the subject at random moments in time, or are likewise experienced by fellow sufferers. Especially the centrality of interpersonal dynamics in psychopathology onset and development has long been a core part of psychological research. Recently, "symbolic diseases" have been linked to the suppressing of feelings that have not been recognized by significant adults, due to experienced difficulties in the communication of concerns and stress related emotions (i.e., "emotional avoidance culture"), specifically emphasizing the pivotal place of others' "*recognition*" (Lind, Delmar & Nielsen, 2014). Landa et al. (2012) observed the unmet need for *closeness* with others as the main internal representation of relationships in the majority of patients diagnosed with DSM-IV-TR (American Psychological Association, 2000) somatization syndromes. In structural, psychodynamic diagnostics and practices, the drive towards closeness is generally related to *hysterical neurosis*, from which (as discussed above) the study on somatic conversion reactions actually originated (Breuer & Freud, 1955 [1895]), and which constitutes the topic of the present paper. More in particular, Blatt's symptom specificity hypothesis (1974, pp. 155-157) distinguishes between a *dependent* (or hysterical) and an *autonomous* (or obsessional) interpersonal style, as the two basic relational types to be underlying the neurotic field. The dependent style would be differentially associated with bodily symptoms and phobias, which are considered to be exaggerated attempts to install closeness towards significant others; the autonomous style, on the other, is hypothesized to be related to obsessive-compulsive symptoms (e.g., obsessional ideas, compulsions, pathological doubt, inhibition), as exaggerated endeavors towards self-definition and separation from others.

Over the past decade, the classical symptom specificity hypothesis has been put to the test in several cross-sectional group studies, yet failed to yield consistent results (for a review, see Desmet, 2007). The inconsistency has recently been ascribed to several conceptual and methodological limitations inherent to the nomothetic research designs of cited studies (see Cornelis et al., 2016). At a *conceptual* level, it was advocated that specific operationalizations of the classical hypothesis plausibly implied critical underestimations of the complexity of associations (see also Desmet, 2013). Blatt's theory essentially describes complex, clinical interplays between interpersonal and symptomatic dynamics over time. Hence, at a *methodological* level, sound examination of these dynamics ideally requires longitudinally, clinical data that enable co-variations between both levels to be studied throughout the course of a therapeutic process. However, cited studies on symptom specificity documented *static* associations, according to their cross-sectional designs, and focused on *typical* or invariant *patterns* in participant groups, which disregarded intra-individual variability and (possibly significant) contextual factors as noise in the attempt to provide rule-based (abstract) knowledge.

However, in order for theories to be clinically useful (i.e., able to directly inform everyday clinical practice), they need to account for *patterns* across multifarious therapeutic processes, as well as *variations* in the specific applicability of group-based findings to the *singular contexts* of everyday practice, in which multiplex determinants move in ongoing processes, and in which many research consumers are most interested (e.g., Flyvbjerg, 2006; McLeod, 2013; Stiles, 2009). Specific deviations

from typical patterns might significantly point to areas where hypotheses call for *refinement* and established theories need to grow, in order to maintain a scientifically beneficial status (e.g., Stiles, 2009). Since empirical case studies enable to cover (possibly relevant) areas that might be overlooked in nomothetic research designs (e.g., Iwakabe & Gazzola, 2009), they prove most valuable for hypothesis refinement and according "theory building" (Stiles, 2009). In integrating intra- and extra-therapeutic contextual influences into thick descriptions of naturally unfolding processes over time, rigorously conducted case studies enable to contribute to scientific development in a unique and clinically meaningful manner (Edwards, Dattilio & Bromley, 2004; McLeod, 2013).

Aims and hypotheses

Attempting to meet the raised shortcomings, Cornelis et al. (2016) advanced a research methodology (discussed below) intentionally designed to address progressive associations between subjects' symptomatic and interpersonal functioning throughout longitudinal processes. The present study explicitly applies this methodology to examine symptom specificity in an empirical case study of a patient presenting with conversion disorder. The studied treatment took place in a real-world clinical practice and was conducted according to Luborsky's (1984) manual of *supportive-expressive psychodynamic psychotherapy*. Concretely, the study's aim is two-fold: (1) to test the applicability of concrete operationalizations of the classical symptom specificity hypothesis for this patient (see below); (2) to broadly examine and describe the gradual, natural unfolding of dynamic symptom-interpersonal interactions throughout treatment.

To provide conformity between the supportive-expressive therapy under study (Luborsky, 1984), and empirical investigation of the narrative data extracted from this therapy, patient's interpersonal functioning is studied by means of the *Core Conflictual Relationship Theme* (CCRT; Luborksy & Crits-Christoph, 1998) method. This methodology is specifically rooted in Luborsky's (1962) theory that subjects' interpersonal exchanges go back to a typical 'core conflict', which consists of three major components (Luborsky & Crits-Christoph, 1998): (1) 'Wishes' (W) with which subjects enter relational exchanges; (2) subjects' subsequent perception of how others react to these wishes ('Responses of Other', RO); and (3) their own reactions to these ROs ('Responses of Self', RS). Since symptoms are theorized to be grounded in subjects' core conflicts, therapeutic interventions that target these conflicts would bring about interpersonal and collateral symptomatic transformations (Luborsky, 1962, 1984), as previously evidenced by e.g., Grenyer and Luborsky (1996), Luborsky and Crits-Christoph (1998), and Slonim, Shefler, Gvirsman, and Tishby (2011).

To strengthen 'credibility' of the results (Morrow, 2005) and enhance a rich understanding of the data (Dattilio, Edwards & Fishman, 2010), *Consensual Qualitative Research for Case Studies* (CQR-c; Jackson, Chui, & Hill, 2011) is used as an overarching data-analytic approach. In CQR-c, 'triangulation' procedures are specifically installed to address complex data through multiple

perspectives in a research team. Team members engage in various discussions of competing and complementing interpretations until all agree on the best representation of the data.

In contrast to the sole reliance of above-cited nomothetic research on patient-reported, quantitative assessment of symptoms and interpersonal characteristics, in this study, *extensive multiple method and multiple source data sets* are analyzed, in order to register various aspects of possible changes in the studied phenomena (e.g., Hill, Chui, & Baumann, 2013). Patient's symptomatic, general and interpersonal well-being were assessed regularly throughout treatment and follow-up, from perspectives of patient, therapist and researchers, in both a quantitative and qualitative manner (see Method).

The combination of CQR-c and CCRT-methodology has recently been administered in three previous empirical case studies (two on obsessional neurosis, see Cornelis et al., 2016; Cornelis et al., under review; and one on hysterical neurosis, see Chapter 4 of this doctoral dissertation).

In line with expectations, all studies reported meaningful interactions

- between patients' symptomatic and interpersonal level of functioning
- between psychodynamic interventions focusing on working-through (e.g., Blatt, 1974, 2008; Verhaeghe, 2004) interpersonal conflicts, and transformations in patients' interpersonal and symptomatic behavior.

In contrast to predictions based on the classical symptom specificity hypothesis (yet in accordance with the more complex theoretical underpinnings, e.g., Freud, Lacan, Blatt, Luborsky), both case studies on patients with obsessional pathology documented profound *ambivalences* between autonomous and dependent interpersonal stances, and accordingly advanced proposed refinements of the classical hypothesis.

Dissimilarly, the previous case study on hysterical pathology reported the predicted *dependent* interpersonal profile. The present empirical case study will, therefore, start again from the same operationalizations of Blatt's symptom specificity hypothesis (see below), and further explore clinical complexity of associations between hysterical symptoms and interpersonal dynamics.

As such, operationalizing interpersonal functioning by means of the CCRT-method, the classical symptom specificity hypothesis (Blatt, 1974, pp. 155-157) leads up to the following **predictions** with respect to symptomatic-interpersonal associations in the patient under study:

H1: Before therapy (during the intake phase) we expect dissociative symptoms to be accompanied by a dependent interpersonal style, expressed in an exaggerated emphasis on interpersonal relatedness and closeness to others.

H1a: Quantitatively, we expect the patient will show an overall higher dependent than autonomous sub-profile on the Inventory of Interpersonal Problems (IIP-32; see Desmet, Meganck & Vanheule, 2013).

H1b: Qualitatively, we expect the following CCRT-components (Luborsky & Crits-Cristoph, 1998, p.46-48) to underpin the patient's relational exchanges: 'Wishes' to be respected, liked, dependent, close, have trust, help, be helped, avoid rejection, not be hurt; a particular sensitivity to the following 'Responses of Other': distant, not accepting, hurting, not trustworthy, not cooperative, and disliking the subject; triggering the following 'Responses of Self': feel dependent, uncertain, disappointed, angry, depressed, unloved, anxious.

H2: Throughout therapeutic process, we expect supportive-expressive therapy to reduce exaggerated strivings towards interpersonal closeness, and dissociative symptoms to subsequently diminish.

H2a: Quantitatively, we expect that scores on the IIP-dependent profile will decrease progressively throughout therapy, and that decreasing IIP-scores will be correlated with declining scores on symptomatic and general ill-being.

H2b: Qualitatively, we expect that changes in the dependent CCRT's throughout therapy (particularly in the RO- and RS- components, e.g., Crits-Christoph & Luborsky, 1990; Grenyer & Luborsky, 1996) will be accompanied by changes in dissociative symptoms.

Method

Participants

The patient was a 33-year old Caucasian man who was referred by the University Hospital for severe tinitus (i.e., whistling sound in the ears) and back pain complaints that could not be fully medically explained. He was a college graduate and worked as a student counselor at the local secondary school. At intake, he met *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) criteria of conversion disorder (axis I; no personality disorder was diagnosed on axis II). Patient provided written informed consent (approved by the University Ethics Committee) to participate in the study and to publish the individual case materials. All possibly identifying information has been changed to protect confidentiality.

The therapist was a 34-year old Caucasian man, who held a PhD in clinical psychology, received three-year postgraduate training in Freudian-Lacanian psychoanalytic psychotherapy, and had six years of clinical experience at the start of therapy.

The research team that carried out the data-analyses consisted of an assistant professor, two postdoctoral researchers, a PhD fellow, and a university student (four females, one male). They were all trained or following training in Freudian-Lacanian psychoanalytic psychotherapy. All research members were Caucasian and ranged in age 24-35 years.

Therapy

Patient received 87 (40- to 60-minute) sessions of supportive-expressive psychoanalytic psychotherapy (Luborsky, 1984) over 3 years, conducted in the therapist's private practice without

interference of the research team. Session frequency varied between once a week and once every month, with an average frequency of twice a week (see Figure 1). In-depth discussion of the therapeutic process, including specific examples of supportive and expressive techniques, is provided in Results Step 3.

Measures

Symptoms and General Well-being.

The General Health Questionnaire - 12 (GHQ- 12; Goldberg, 1972; Koeter & Ormel, 1991) is a 12-item self-report questionnaire used to assess general psychological distress. Items are scored using a 4-point Likert scale. The GHQ's validity and reliability was demonstrated by Koeter and Ormel (1991), and by Vanheule and Bogaerts (2005) for the Dutch version.

The Symptom Checklist - 90 - Revised (SCL-90-R; Derogatis, Lipman, & Covi, 1973) is a 90-item self-report questionnaire assessing general psychological and physical functioning with good psychometric qualities (Derogatis, 1994). Items are scored on a 5-point Likert scale.

The Global Assessment of Functioning (GAF; APA, 1987) scale is a widely used clinician- or researcher rated measure of psychiatric symptom severity and functioning on a psychological, social and occupational level. The scale can be used to track clinical progress of individual patients in global terms. The overall GAF scale scores range from 0 to 100 and are divided into ten deciles of functioning. GAF rating involves selecting one single decile that best reflects the patient's overall level of functioning at the time of evaluation.

Health care costs were retrieved via the patient's health insurance fund, spanning from two years before treatment onset until third follow-up assessment 2 years and 11 months after treatment termination. Costs include medication use (i.e., psychotropic and other), medical consultations (ambulant and residential, excluding the psychotherapy sessions discussed in this paper) and job absenteeism.

The Semi-structured Change Interview (SCI; Elliott, 1999; Elliott, Slatick, & Urman, 2001). This in-depth qualitative outcome interview was administered by a researcher at the second follow-up (1 year and 10 months after treatment termination) and is used to assess the way the patient experienced the therapeutic process. The patient is asked about what changes occurred during therapy, the processes that might have brought about these changes, whether any of the changes were surprising to him/her, and what aspects of the therapy he/she experienced as helpful, difficult, hindering, or missing.

Interpersonal Functioning.

The Inventory of Interpersonal Problems - 32 (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000) is a 32-item self-report questionnaire with eight subscales reflecting different interpersonal problems. Items are scored on a 5-point Likert scale. Psychometric properties of the Dutch version were positively evaluated by Vanheule, Desmet, and Rosseel (2006). Desmet et al. (2008) developed a scoring system for an anaclitic/hysterical and an introjective/obsessional IIP profile.

The Core Conflictual Relationship Theme (CCRT) Method (Luborsky & Crits-Christoph, 1998) is a qualitative, systematized and reliable measure of the central relationship patterns that pervade self-other interactions (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2000). Within the

patient's narratives, two researchers selected Relationship Episodes (RE's), i.e., discrete episodes in which the patient spontaneously spoke about concrete relational exchanges, decomposed in (see Introduction): (1) 'Wishes' (W), (2) 'Responses of Other' (RO), and (3) 'Responses of Self' (RS). The most typical W's, RO's and RS's constitute the final CCRT-formulation.

Procedure

Data collection happened as follows: (1) therapy sessions were audiotaped by the therapist, and transcribed verbatim by a postgraduate research assistant; (2) after every session (2a) patient completed GHQ-12 and IIP-32 questionnaires in the therapy room in presence of the therapist, and (2b) therapist made a brief session report in which important dynamics at the level of symptomatology and interpersonal functioning were summarized; (3) after the first session, after every eighth session, and at three follow-up assessments (i.e., respectively 8 months, 1 year and 8 months, and 2 years and 11 months after treatment termination) (3a) patient completed a more extensive set of questionnaires at home (i.e., GHQ-12, IIP-32, SCL-90), and (3b) GAF-scores were administered by a research team member (except for first and third follow-up, at which patient individually completed questionnaires that were sent to his residence by mail); (4) at second follow-up, SCI was administered by a research team member; (5) at third follow-up, health care cost information was retrieved by another team member.

Data analysis

Data-analysis included three main steps (as previously been described in Cornelis et al., 2016): a quantitative and qualitative outline of (Step 1) symptomatic evolutions throughout therapy, (Step 2) evolutions in interpersonal functioning, and (Step 3) their associations, embedded within a broader, clinical description of the therapy process.

In Step 1, one member of the research team (below referred to as 'researcher 1') constructed graphs on quantitative evolutions in all outcome measures of symptoms and general well-being (see Figures 1 and 2). To assess significance of change, the ACORN Toolkit (specifically designed to help clinicians and researchers calculate change related statistics for a variety of outcome measures; Brown, Simon, Cameron, & Minami, 2015) was used to calculate Reliable Change Indices (RCI; identical to RCI formula of Jacobson and Truax, 1991, but with one-tailed 95% confidence intervals; see Brown et al., 2015) and Severity Adjusted Effect Sizes (SAES; Brown et al., 2015). Next, two research team members (i.e., 'researchers 1 and 2') attentively listened to audiotapes and read the transcripts. Both were equally informed of relevant patient demographic information and therapy characteristics (see Hill, 2012), but researcher 2 was blind to the quantitative graphs. Both researchers separately identified all events where the patient explicitly referred to his symptoms, and marked symptomatic evolutions throughout therapy with respect to intensity, content or form. Through subsequent discussion on the most profound changes, consensus was reached on identification of the main 'tipping points' (i.e., specific moments in the chronicle of events that turn out to be crucial for further development; Tarrow, 2004). In case of divergence, members engaged in discussions in which they questioned each other on their ideas, enabling every opinion to be fully expressed and understood (see also Jackson, Chui, & Hill, 2011; Schielke, Fishman, Osatuke, & Stiles, 2009) until

both members agreed on the best representation of the data (Hill, Thompson, & Williams, 1997). A concise qualitative description of symptomatic evolutions was provided by researcher 1, reviewed by two other team members (of which one was familiar with the raw narrative data), and consequently refined.

In Step 2, researcher 1 constructed similar graphs on evolutions throughout therapy in interpersonal characteristics (see Figure 3), depicting IIP-32 total, dependent and autonomous scores (see Vanheule, Desmet, & Rosseel, 2006). Again, RCI and SAES were computed using the ACORN Toolkit (Brown et al., 2015) to assess significance of change. Next, researchers 1 and 2 conducted CCRT analyses for the first therapy sessions, the 'tipping point'-sessions selected in Step 1, and the last sessions. In a first phase, both researchers attentively re-read transcripts of the identified sessions, individually selected all RE's that were suitable for CCRT coding (i.e., RE's that contained W's, RO's and RS's), and gathered to select by consensus the 10 most informative RE's. When sessions yielded less than 10 informative RE's, additional RE's were selected from the preceding and/or following sessions. In a second phase, selected RE's were then written down in a separate document and coded using the standardized coding system (Standard Category List, Edition 2; Luborsky & Crits-Christoph, 1998, p.26). In line with Hill et al. (2011), judges distinguished between (a) RE's describing interactions with *specific people*, and with *people in general*, (b) W's, RO's and RS's occurring in *all* RE's (General, G), in *at least half* of RE's (Typical, T), and in *less than half, but at least two* RE's (Variant, V). Researchers strived towards consensus on identified RE's (phase 1) and CCRT-codes of identified RE's (phase 2). In case of divergence, researchers engaged in extensive discussions (see Step 1), and gradually refined initial ratings by integrating valuable contributions of the other until consensus codes were reached (see Hill, 2012). Judges' proportions of agreement (RE's: .83, W's: .72, RO's: .89, RS's: .77) indicated high correspondence for initial ratings. Finally, researcher 1 organized consensus CCRT-codes in Tables 1 – 3, which were checked for accuracy and comprehensiveness by researcher 2.

In Step 3, researcher 1 calculated longitudinal intra-subject associations (i.e., correlations between two series of repeated measures within the same subject) between evolutions in patient's symptomatic, general and interpersonal level of functioning. Next, researcher 1 engaged in a 'thick description' (Pontoretto & Grieger, 2007) of the longitudinal, clinical interplay between both levels throughout therapy, in which changes in quantitative measures were linked to the treatment narrative (Dattilio, Edwards, & Fishman, 2010) and significant therapist interventions and extra-therapeutic events were discussed. Several precautions were taken to reduce researcher 1's biases and expectations and to present a 'truer' account of the data (see Hill, 2012): prior to writing, researcher 1 orally presented provisional analyses to a third research team member (unfamiliar with the case data, but acquainted with the theoretical orientation and phenomena of interest, and informed about the research questions), who extensively questioned her in order to focus findings more clearly in response to research questions; during the writing process, researcher 1 continually returned to raw materials to stay close to the patient's narratives, and included sufficient detail and literal quotes of the

patient to validate presented findings; finally, the manuscript was reviewed several times by two team members (i.e., the third researcher described above, and a team member who was familiar with both case data and research questions) to identify areas in need of further attention, which were subsequently refined.

Results

Step 1: Evolutions in Symptomatic and General Well-Being

Analysis of Outcome Data. Figure 1[12] shows a highly fluctuating, but generally decreasing trend over the course of therapy in self-reported general psychological and physical malfunctioning (GHQ-12 and SCL-90 scores), which reaches significance when assessed by means of RCI, both at treatment termination (GHQ-12: RCI = -3.77, $p < .05$; SCL-90: RCI = -3.64, $p < .05$), and at follow-up (GHQ-12: RCI = -3.77, $p < .05$; SCL-90: RCI = -4.90, $p < .05$). Small to moderate SAES are observed, at treatment termination (GHQ-12: $d = 2.26$; SCL-90: $d = 0.89$) and at follow-up (GHQ-12: $d = 2.26$; SCL-90: $d = 1.20$).

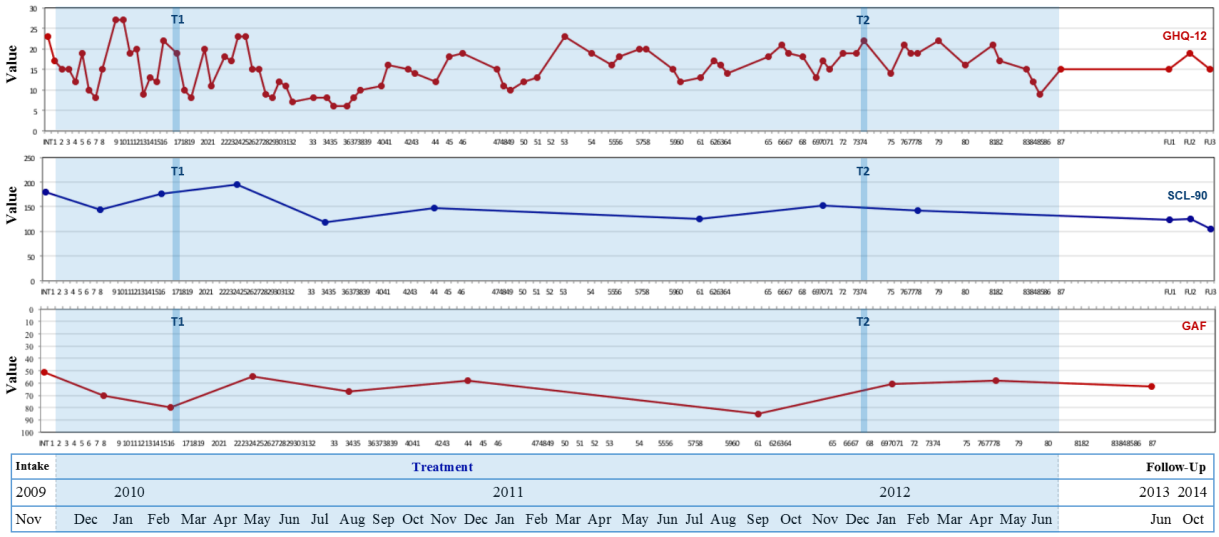

Figure 1. Evolutions in patient- and researcher-rated well-being from intake to follow-up. GHQ-12 = General Health Questionnaire-12; SCL-90 = Symptom Checklist-90-Revised; GAF = Global Assessment of Functioning; T1 = Tipping point 1; T2 = Tipping Point 2.

Next, Figure 2[13] depicts that patient's main health care costs went to frequent consultations of his general health practitioner (GP; 2007 – 2015), of a physiotherapist (for back exercises; June 2013 – December 2015), and of neurologists and accompanying MRI-scans (for back pain concerns; December 2009; June, November, December 2010; October 2011; October 2012; November 2014; December 2015); and a psychiatrist and ear specialist consultation (for tinnitus) right before onset of the psychotherapeutic treatment under study (July – August 2009). In addition, high and regular use of medication was observed (2007 – 2015), i.e., mainly migraine medication, antidepressants, and

[12] Figure 1 is also presented vertically in Appendix 1.
[13] Figure 2 is also presented vertically in Appendix 2.

painkillers (for back pain; June 2010 – 2015). Ambulant or residential hospital care was not observed (except for the comprehensive diagnostic procedure right before the onset of psychotherapy; as described below); periods of job absenteeism due to a physical or psychological condition were also absent.

In terms of average health care costs per month, costs were highest during the treatment (€160/month) and follow-up period (€155/month), due to the simultaneous start of both psychotherapy and regular neurologist and physiotherapist consultations (and accompanying medication) for back ache complaints. (Cheaper) GP consultations (and accompanying medication) compiled the main pre-treatment costs (€97/month).

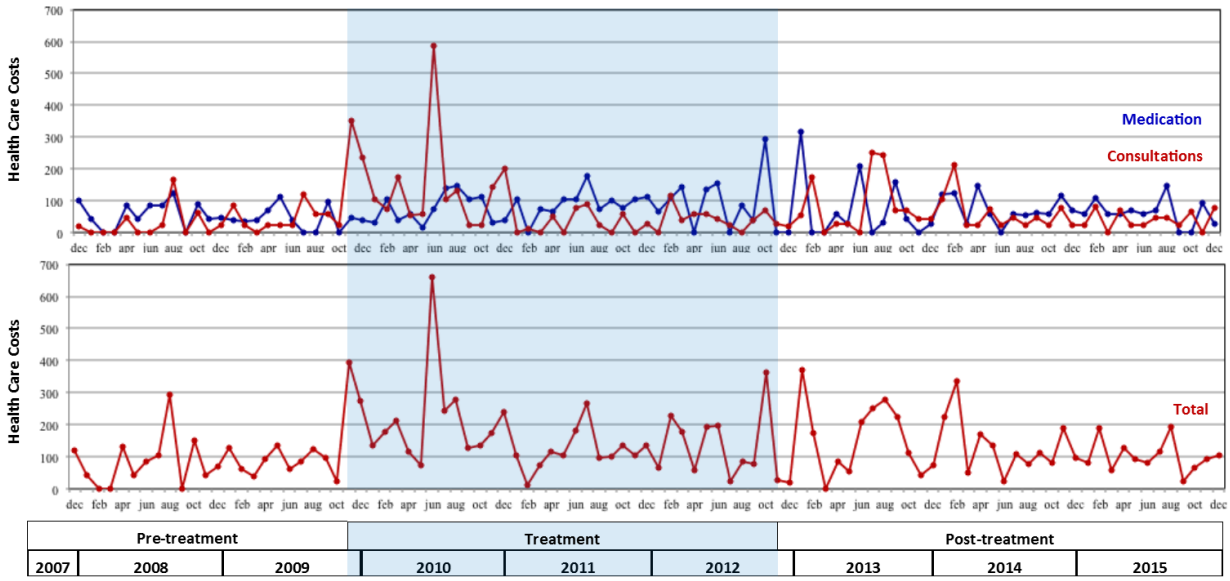

Figure 2. Evolutions in patient's health care costs (euro) from two years before onset of treatment until follow-up.

Qualitative Description of Evolutions. *Preliminary note*: since subjects' natural language "more closely represents the psychological reality of human experience" (Camic, Rhodes, & Yardley, 2003), literal wordings of the patient (designated by double quotation marks) are quoted to support researchers' remarks.

Nick was referred for psychotherapeutic treatment by the University Hospital he had consulted "in panic" for severe tinnitus complaints. In particular, it concerned the second, sudden and fear-laden emergence of tinnitus after a first episode "four to three years ago". Prior to this first emergence, Nick had suffered since a few years from so-called 'disco-tinnitus', i.e., temporarily hearing a whistling sound in his ears after having played loud music with his rock band. Considering this phenomenon as "the hallmark of a true musician" he had always been proud of it. Four/three years ago, however, tinnitus had abruptly, and inexplicably, become charged with intense fear and guilt. By means of antidepressant and sedative medication, and frequent (temporarily reassuring) consultations of his general practitioner, Nick had managed to embank the flood of anxiety and had regained a delicate balance (i.e., little interfering with his psychic/social/occupational functioning). Yet, a few months

before the onset of (current) treatment, anxiety had again burst it banks, and tinnitus had drastically resurfaced, together with "the start of severe panic attacks". As his habitual way of coping did no longer suffice, he had contacted the University Hospital in the hope of receiving "a more specialized treatment". A comprehensive diagnostic procedure identified minor ("objective") hearing damage, which could not explain the ("subjective") intensity of the sound and accompanying panic.

In addition to tinnitus, Nick suffered from intense back pain complaints, similarly disproportionate to the minor ("objective") signs of "natural wear" that generally accompanies human aging process.

Both tinnitus and back pain were accompanied by intense worry/doubt, profound fears of "doing anything that would intensify the damage in any way", constant restlessness/agitation, difficulties sleeping, and had prompted him to discontinue former musical and sports passions.

As further discussed in more detail (see Step 3), Nick's symptomatic and general well-being fluctuated considerably throughout therapy up to session 32 (see also Figure 1), from which point Nick proclaimed to "feel that something had changed". Significant peaks in his suffering occurred in session 17, coinciding with the (fearfully anticipated) birth of his first-born child *(tipping point 1)*, and in session 74, during which he admitted to have committed adultery, accompanied by intensely ambivalent feelings towards both his mistress and wife *(tipping point 2)*. A medical checkup preceding session 57 indicated that the "objective" hearing damage had disappeared; yet, back pain (and occasional tinnitus) complaints prolonged in varying intensity until the end of therapy.

In marked contrast to regular reports of weekly medical consultations during therapy sessions, Nick stopped consulting his general practitioner from session 42 onwards, except for session 68 (in which strong, not-expressed anger/agitation had temporarily manifested in increased back pain and tinnitus). Towards the end of therapy, symptoms diminished significantly, Nick regained some "control" over his troubling thoughts (i.e., he did no longer "lose" himself in "endless worrying"), resumed his musical ambitions with renewed vigor, exercised at a high level again and attained the desired job promotion. Though his general well-being remained relatively stable, increased "tension" at work started resulting in regular headaches and occasional aggressive outbursts at home.

During the follow-up interview (i.e., one year and 11 months after treatment termination), Nick affirmed that tinnitus complaints had remained absent and that backaches "had not intensified" (i.e., remained stable, except for occasional, fear-laden upsurges). Yet, to his own regret, he still could not master job-related stress and "tensions at home" sufficiently without the help of antidepressant medication.

Step 2: Evolutions in Interpersonal Functioning

Analysis of Outcome Data. Figure 3[14] shows a fluctuating course in self-reported interpersonal problems throughout therapy. Reliable Change Index indicates a significant overall decrease in IIP-32 total scores throughout treatment (RCI = -3.09, $p < .05$), corresponding with a large severity adjusted effect size ($d = 1.24$). After treatment termination (i.e., during the follow-up period),

[14] Figure 3 is also presented vertically in Appendix 3.

self-reported interpersonal problems rise again to pre-treatment levels, however, resulting in an overall non-significant difference with treatment onset (RCI = - 0.41, *ns*); and corresponding low effect size (*d* = 0.16).

Overall during treatment and follow-up, the dependent interpersonal profile proves higher than the autonomous profile. Markedly, up to session 60, self-reported autonomous problems remain low to non-existent, while dependent sub-scores fluctuate intensely. From session 61, fluctuations also arise in autonomous problems, and both sub-profiles now reflect similar trends, with several observed peak values (which will be addressed in the qualitative description of the therapy process in Step 3).

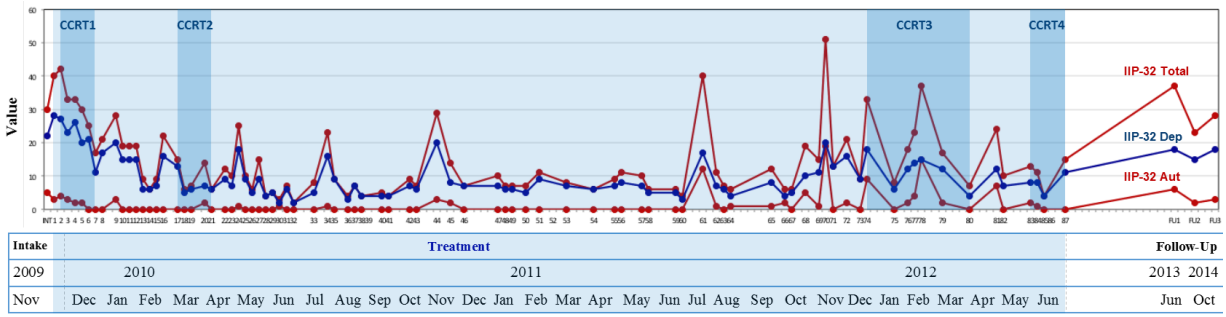

Figure 3. Evolutions in patient-reported interpersonal problems from intake to follow-up. IIP-32 Total = Inventory of Interpersonal Problems-32 total scores; IIP-32 Dep = Inventory of Interpersonal Problems-32 subscores dependency; IIP-32 Aut = Inventory of Interpersonal Problems-32 subscores autonomy; CCRT1 = Conflictual Relationship Theme codings of first three sessions; CCRT2 = Conflictual Relationship Theme codings of Tipping point 1 sessions; CCRT3 = Conflictual Relationship Theme codings of Tipping point 2 sessions; CCRT4 = Conflictual Relationship Theme codings of last four sessions.

Analysis of CCRT-codings. Before discussing the main findings presented in Tables 1 – 4, it must first be noted that interpersonal references in the patient's discourse were overall reported as general accounts of typical, context (i.e., time and place) independent relational exchanges, which were seldom spontaneously linked to specific (past or current) events (see how this is reflected in a predominance of 'general' W's, RO's and RS's in Tables 1 – 4). Discrete RE's containing concrete W's/RO's/RS's thus proved scarce. In addition, other people (even the patient's wife, son and boss, who recurrently appeared in the patient's speech during every session) were seldom mentioned by name, except for the last therapy sessions. However, the patient proved eager to answer copious therapeutic inquiries after specific CCRT-components (e.g., "How did she react?", "Can you describe more precisely what you were missing or desired during those interactions?").

CCRT's in RE's With Specific Others.

With General Practitioner/other medical experts. Up to session 42, Nick consulted his general practitioner at least weekly in the hope of (W) expressing his anxiety-rising thoughts and "being affirmed" in his concern "that my fears/thoughts are faulty and unsound, and that the objective damage is still small". In his family of origin, communication had always centered on physical ailments and medical solutions, and regular visits to the family's GP were custom ("We were raised with operations and clinical images, and medications had always been present"). Nick perceived his GP as compassionate, understanding and open (RO), each time able to temporarily embank the flood of

anxiety (RS), until new concerns and symptoms arose (RS; “I wonder when I will finally believe what the GP and other doctors tell me, because I cannot reassure myself with their message, as I always find something else”). Since session 42, Nick stopped consulting his GP (except for session 68; see Step 1).

With mother. In early sessions, Nick and his mother contacted each other daily on the phone (W, RO) to complain about their physical ailments and his pessimistic, alcohol-addicted father, whom Nick considered to be the main cause for his mother’s misery and psychic issues (e.g., for as long as he could remember she had been taking antidepressants). In sharp contrast to his father, he described his mother to possess a much kinder and more accessible nature (RO): she had always functioned as “moderator” in communication between his father and the rest of the family. Throughout therapy, however, nuances appeared in this one-sided image. Together with Nick’s growing awareness of overall wishes (W) to be his own person (i.e., not to conform to the image of the suburban bliss his parents held out) and to be liked (i.e., others to be truly interested in “me as a person, in my interests, passions and ambitions”), he progressively began to voice longstanding disappointments with respect to their relationship, which had always been “solely focused on complaints and misery”. He had always felt constrained (RS) – and experienced her as distant and not understanding (RO) – in “discussing true emotions” and “interesting topics” with her, and increasingly began to voice disappointments (RS) with respect to her longstanding lack of active support and indifference towards his musical ambitions, despite her own past as praised accordion player (RO). Paired with rising frustrations and anxiety (RS) facing “her implicit demands to stand up to my father and put him in his right place” (RO), these negative RO’s and RS’s increasingly prompted him to stop contacting his mother (RS), though deeply rooted, overall wishes to avoid conflict (W) inclined him to hold his tongue (i.e., not expressing his frustrations to her) while answering her daily calls and listening to (RS) her repetitive complaints (RO).

With father. In early sessions, Nick described his father to be “the complete opposite” of his mother, his “absolute anti-model” whom he avoided as much as possible (RS): the “ever complaining, insufferable pessimistic”, “one big chunk of frustration” who was “pre-occupied with making safe choices in life that led to (financial) security”, who had “never accomplished anything in his whole life out of fears”, and “held others back in their ambitions as well”, i.e., “making their lives a misery” by “constantly brooding on worst case scenario’s” (RO). Yet, he considered his father to be a strong authority figure (RO, “though he had never earned this position in the slightest”), whom he respected and feared (RS). He dreaded “confrontations” with him, during which he had always felt “paralyzed” (RS). “Intense fears to end up like my father” impeded him in peacefully assuming his own, dependent wishes towards a “boring, mainstream” comfortable family life (W), and in “enjoying quiet moments”, but stimulated him instead to constantly “prove” himself. In answer to therapeutic queries to elaborate on (casual mentions of) his father’s former cycling ambitions, social engagement and political interests, Nick increasingly began to nuance this longstanding one-sided characterization of his father throughout therapy. Simultaneously, he progressively voiced long misrecognized wishes for his father to be truly interested in him (W) and urges to be accepted, respected and given support by his father

(W); whose lack of support and indifference towards his identity as a hard-core musician (RO) had always made him feel uncertain, anxious and inhibited (RS).

With father-in-law. Nick generally experienced his father-in-law (who frequently came visiting to help with the renovation work) as controlling, dominant and not understanding (RO), and increasingly wished to have control and have things his own way, without the latter's interference (W). In considering him as a strong authority figure (RO), however, he experienced similar, negative RS's in relational exchanges. Overall urges to avoid conflict and be respectful and abiding towards authority figures (W, RS), stimulated him to be submissive and hold his tongue towards him (RS), yet, accompanied by aggravating back pain complaints.

With authority figures (i.e., school board, teachers) and students at work. Throughout the entire therapy, Nick sharply contrasted "the students" at the school where he worked as students' counselor, to the so-called "authority figures", i.e., the school board and "the teachers"; whom he perceived as "hierarchal higher" and with whom he described the same (mainly negative) RO's and RS's characteristic of RE's with his father. He greatly valued his job as a "moderator between students and teachers" and gained much satisfaction from the "meaningful contacts with students", with whom he felt "valued, respected and influential" (RS). Throughout therapy, he sharply contrasted his experiences of "truly meaning something, being active, creative and highly productive" (RS) "in the work situation" to the passivity and meaninglessness he encountered (RS) "in the home situation". Despite his ambitious nature and innovative ideas (W), however, he generally felt uncertain, and only felt safe "working under the wings of a [supportive] superior" (i.e., "being the steersman, not the captain", RS). As a result, other staff members generally got the credit for his hard work. Experienced disunity between one (long existing) part of his identity as "the tattooed, head banging, not-conforming hard-core musician", and another (newer, and more uncertain) as "the formerly dressed, well-mannered, achieving member of the school board" strongly incited feelings of uncertainty and ambivalence. Over the course of therapy, Nick increasingly succeeded in "paddling my own canoe" and attained "a job position with more responsibility and influence," though he still frequently missed (RO) the desired approval and support (W) from authority figures.

With wife (whom Nick generally referred to as "my wife" instead of using her name). In early sessions, Nick generally described highly positive, safe and comfortable interactions (RS) with his caring wife, with whom he had been together for ten years at the start of therapy. Home was "the only place I could calm down and rest my head" after busy workdays. In great contrast to his parents, she "had always supported me in all endeavors" (RO). He frequently felt guilty (RS) towards her for his tinnitus and intense back pain complaints (RS) which "held up progress" regarding the renovation work at their house (RS). However, in answer to therapeutic queries after (initially puzzling/isolated) irritations, feelings of passivity, incompetence and "usefulness" at home (RS; in great contrast to his productivity at work), he soon began to voice resentment (RS) towards her "domination" in "having imposed her wishes to buy a house and start a family" (RO). Gradually, he began to consider his symptoms as a means of "passively opposing" the immediate realization of his wife's desires, as his somatic complaints – and the accompanying pathological (e.g., very intense, time and energy consuming) doubt and inhibition to act – enabled him to delay completion of renovations at the old

house which was not yet “fit for a child to live in”. In his experience, the “irreversibility” of “being tied to a house and family” collided with his (long contained) urges to achieve and to “be creative” during rehearsals and performances with his hard-core band and in setting up innovative projects at school (W); resulting in feelings of disappointment and anger (RS), and in phantasies about being completely free from any family responsibility (W). Yet, profound longings to avoid conflict, and fears that his “relationship would end, otherwise” prompted him to reluctantly go along with his wife’s wishes. Similarly to described evolutions towards his parents, Nick increasingly experienced his wife throughout therapy as indifferent and not truly understanding his interests and ambitions (RO); which entailed rising disappointment and distance towards her (RS). Augmenting resentment (RS) regarding her dominance (RO) increasingly resulted in aggressive outbursts at home (which had, in the second half of therapy, become the main source of “restlessness, agitation and pressure”) and in a brief period of committing adultery (RS), which made him feel temporarily “free, happy, independent and controlling” (RS). Towards the end of therapy, he ended this affair and tried to attain new means of compensating for what he missed at home in elevated musical, sports and occupational investments.

With Susan (mistress). During two months, Nick had a brief affair with a woman he had been friends with for a long time. He did not find her more attractive or smarter than his wife, but received during contacts with her the desired, positive RO’s he missed in contacts with his wife. Besides positive RS’s, Nick experienced this period as highly ambivalent (RS), as he still loved his wife and felt guilty towards his children. Love and respect for the latter eventually incited him to end his affair and choose for his family.

With children (whom Nick generally referred to as “the children” instead of using their names). During therapy, Nick and his wife had two children. Both births were highly desired by his wife, but unwanted by him. Throughout treatment, however, he reluctantly – almost shamefully – admitted to start caring for his children (whom he started calling by their names during sessions), since for him, this affection (a) resembled the image of “the mainstream, boring suburban existence” too much, which was held out by his father and against which he had so fiercely rebelled; (b) accordingly, collided with the image held out by hard-core musicians of “being free to do as you please” and “being able to spontaneously change directions in life” without “being restricted” by other people or (familial) obligations. “Caring for” someone was typically experienced by Nick as “a burden”, as it equaled “bearing responsibility for” that person, which in turn comprised “worries” and feelings of “powerlessness”, entailing “pressure and tension”. Unto follow-up, Nick’s affection for his children and “growing enjoyment of family time”, kept disturbingly interfering with his desired identity of non-conformist and with deep-seated feelings “of wasting time I could otherwise have spent useful” (e.g., working, creating).

With co-sportsmen/audience musical performance. Towards the end of therapy, Nick progressively re-invested in sports and musical ambitions. In addition to the solitary act of mountain biking (to “ride off the piled up frustrations”), he joined a sports club, where he particularly enjoyed (RS) the close, amicable contacts with equally minded team members (RO, W). Similarly, intensely positive RS’s rose from joint creative work, and mutual respect and acceptance (W, RO, RS) during

rehearsals with his music band, and from RO's of appreciation and admiration from the audience. However, feelings of guilt and/or worry occasionally converted in aggravated tinnitus complaints.

With therapist. Interactions with the therapist are not delineated separately in Tables 1 – 4 due to absence of (a) clear CCRT-components in enacted interactions during sessions, and (b) narrations about therapy/therapist experience. Yet, it can be noted that (1) throughout the entire treatment, Nick was very forthcoming with respect to the 'formal' framework of therapy: he always arrived on time, never failed to have the exact amount of money ready, and only missed a session once during the three year course of therapy, due to overtime hours at work; (2) (in similarity to earlier described means of passively resisting domination out of fears to actively contradicting/opposing his wife, father and other "authority figures"), Nick often reacted to therapeutic interventions by immediately acknowledging the therapist's remarks, then simply resuming narration as if there had been no interruption; (3) in line with his initial sharp distinction between "the objective, medically identifiable, bodily damage at my ears and back", and "the "psychological part" (i.e., "the radars in my head, the dramatizing thoughts and fears that intensify the objective pain"), Nick initially addressed the therapist to help him "disperse of these harmful mechanisms" and "acquire more adaptive strategies to cope with the bodily symptoms", while he continued to regularly consult medical experts – i.e., unto session 42, by which point Nick had come to appreciate "the unexpected turn" therapy had taken as "highly stimulating" (e.g., "discussing the position I typically occupy in interpersonal relations", "finding connections",…).

CCRT's across all interaction patterns. Throughout treatment, Nick increasingly became aware of an overall destabilizing, "tension-laden" conflict (RS) between different parts of his identity, which he intensely longed to unite into an undivided sense of self (W), but which he found extremely hard to reconcile (RS), i.e., (a) on the one hand – out of fiercely battled conformity to the law-abiding suburban bliss and safe/secure life paths outlined by his anxious father – his appearance as a rebellious, tattooed, opinionated hard-core musician, exempt from familial life, with according W's to be free and not be constrained or restricted by other people or obligations (b) one the other, his roles as abiding son, son-in-law, husband, father, and serious, well-mannered, formerly dressed, and well-payed member of the school board, accompanied by wishes to approved of, affirmed, given support, genuinely liked by, and avoid conflict with family members and authority figures. Experienced privations from the desired recognition, interest and support from the latter (W, RO), stimulated Nick to occupy understanding, empathetic, respectful and open positions (RS) towards the students he worked with. Similarly, he put high emphasis on "truly meaning something, being useful, productive and of value" in musical and sports ambitions. In the course of therapy, initial RS's of anxiety, pathological doubt, inertia and somatic complaints, were progressively replaced by RS's of anger, disappointment, dependency, tension and worry. Towards treatment end, he increasingly succeeded in paddling his own canoe and in asserting himself at work and during leisure time (music and sports; RS). However, at follow-up, he had still not found a bearable balance between both sides of the described conflict (RS). Fearfully avoiding interpersonal conflicts, he was still anxious to actively oppose (RS) significant others whom he continued to experience as controlling and dominant (RO).

Table 1
Patient's wishes (W), responses of other (RO), and responses of self (RS) in intake session and therapy sessions 2, 5 and 6

Target of interaction	#	W	RO	RS
General Practitioner	1	Be understood (G), be accepted (affirmed; G), be helped (given support; G), be open (G)	*Positive:* Understanding (G), helpful (G), open (G)	*Negative:* Uncertain (confused; G), anxious (worried; G) *Positive:* Open, accepted (G), comfortable [temporarily] (G)
Mother	1	Be understood (G), be accepted (G), be helped (given support; G), be liked (G)	*Negative:* Not truly understanding/ distant/dislike me [with respect to emotions, interests, passions] (G) *Positive:* Open (G), understanding/helpful [with respect to physical ailments] (G), likes me (G)	*Negative:* [With respect to emotions]: not open (inhibited; G), disappointed (G) *Positive:* [With respect to physical ailments]: open (G), accepted (G), loved (G), comfortable [temporarily; G]
Father	2	Be accepted (approved of, affirmed; G); be respected (valued, important; G), be helped (given support; G), be liked (G), be my own person (G), avoid conflict (G)	*Negative:* Rejecting (G), distant (G), not understanding (G), unhelpful (G), strong (G)	*Negative:* Disappointed (G), dependent (G), uncertain (G), anxious (G), inhibited (G), angry (resentful, irritated; V), guilty (V) *Positive*: Independent (V)
Wife	3	Be understood (G), be accepted (G), be helped (given support; G), avoid conflict (G), oppose (resist domination)/ have control (have things my own way)/ not be responsible/obliged (be free, not be constrained; G), assert myself (T)	*Negative:* Not truly understanding (G), controlling (dominating, taking charge; G) *Positive:* Loves me (G), understanding (empathic; G), helpful [with respect to physical ailments; G]	*Negative:* Dependent (submissive, passive; G), uncertain (G), anxious (worried, nervous; G), angry (resentful, irritated; G); disappointed (T), helpless (incompetent; T), guilty (T) *Positive:* Loved (G)
At work with pupils	3	Be accepted (G), be respected (valued, important; G), achieve (G), be helped (given support; G), not be hurt (avoid rejection; G)	*Positive:* Accepting (G), respecting (G), like me (interested in me; G), give me independence (G), dependent (influenced by me; G)	*Positive:* Accepted (G), respected (G), open (G), helpful (G), self-controlled (G), independent (G), self-confident (G), happy (G), comfortable (G), controlling (influential; G)
Across all interactions	10	Be accepted (G), be helped (G), avoid conflict (T), be liked (T), be my own person (T)	*Negative:* Not truly understanding (G), distant (T), rejecting (T), dislike me (T) *Positive:* [With respect to physical ailments]: understanding (T), open (T) [Work]: accepting (V), respecting (V), like me (V), give me independence (V), dependent (V)	*Negative:* Uncertain (confused; G), anxious (worried; G), dependent (T), angry (T), inhibited (T), disappointed (V) *Positive:* [With respect to physical ailments + at work]: open (T), accepted (T), comfortable (T) [At work]: respected (V), helpful (V), self-controlled (V), independent (V), self-confident (V), happy (V), controlling (V)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Wordings between brackets refer to 'Standard category components' within the precursory 'Standard category'; Therapy sessions 1, 3 and 4 could not be used for CCRT-coding due to inadequate sound quality.

Table 2
Patient's wishes (W), responses of other (RO), and responses of self (RS) in therapy sessions 17 – 21

Target of interaction	#	W	RO	RS
Mother	2	Be understood/ accepted/ respected (G), be open (G), be helped (G)	*Negative:* [With respect to emotions and personal ambitions/interests]: not understanding (G), distant (G), does not like me (not interested in me; G), dependent (G) *Positive:* [With respect to physical ailments]: Understanding (empathic), accepting (G), helpful (G)	*Negative:* [With respect to emotions and personal ambitions/interests]: not open (inhibited; G), disappointed (G), uncertain (G), anxious (G) *Positive:* [With respect to physical ailments]: open (G), [temporarily] comfortable (G)
Wife	5	Be understood (G), accepted (G), be helped (given support; G), avoid conflict (G), oppose (resist domination)/ have control (have things my own way)/ not be responsible/obliged (be free, not be constrained; G), assert myself (T)	*Negative:* Not understanding (G), controlling (G), opposes me (deny/block my wishes; G) *Positive:* Helpful (G), cooperative (G)	*Negative*: Anxious (G), not open (inhibited; G), uncertain (G), angry *[not expressed]* (G), dependent (G), disappointed (unfulfilled; G), depressed (G), oppose [passively, via symptom back pain; G); guilty (G) *Positive:* Comfortable (T), loved (T)
Boss	1	Be my own person (G), be helped (be given support; G), be stable (have structure, security; G), be good (G), achieve (G)	*Negative:* Strong (G) *Positive:* Accepting/ respecting (G), likes me (G), gives me independence (G)	*Negative:* Not open (inhibited; G), uncertain (G), anxious (G), symptom: tinnitus (G) *Positive:* Accepted/ respected (G), controlling (influential; G); self-controlled (G), self-confident (G)
Son	2	Help (G), hurt (G), have control (G), not be responsible/ obliged (G)	*Negative:* Distant (G), controlling (G)	*Negative:* Anxious, uncertain (torn, ambivalent, conflicted; G), dependent (G), symptom: back pain *Positive:* Like (G), helpful (G)
Across all interactions	10	Be accepted (T), be helped (T), avoid conflict (T), oppose/have control (T), not be responsible/obliged (T), be my own person (T)	*Negative:* Not understanding (T), controlling (T), opposes me (T), distant (T), does not like me (T) *Positive:* Helpful (T), cooperative (T)	*Negative:* Anxious (G), not open (G), uncertain (G), angry [not expressed] (T), dependent (T), disappointed (T), depressed (T), oppose [passively, T); guilty (T) *Positive:* Comfortable (T), loved (T)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Wordings between brackets refer to 'Standard category components' within the precursory 'Standard category'.

Table 3
Patient's wishes (W), responses of other (RO), and responses of self (RS) in therapy sessions 74 – 80

Target of interaction	#	W	RO	RS
Father	1	Be accepted (G), be respected (G), be helped (given support; G), be liked (interested in me; G), be my own person (not conform, G), avoid conflict (G)	*Negative:* Rejecting (G), does not like me (G), distant (G), not understanding (G), unhelpful (G), strong (G)	*Negative:* Uncertain (G), disappointed (G), anxious (scared, nervous; G), not open (inhibited; G)
Father in law	1	Have control (G), not be responsible/ obliged (feel free/not constrained; G), avoid conflict (G), be good (G)	*Negative:* Controlling (G), strong (G), not understanding (G)	*Negative:* Not open (inhibited; G), angry [not expressed] (G), guilty (G), anxious (scared, nervous; G), dependent (G), opposing [passively, via symptom: back pain; G), helpless (G), depressed (G)
Boss	1	Have control (G), assert myself (G), be stable (have structure, security; G), be helped (given support; G), avoid conflict (G), achieve (G)	*Negative:* Strong (G), controlling (G) *Positive:* Accepting/ respecting (G), gives me independence (G)	*Negative:* Uncertain (G), anxious (G), symptom: tinnitus (G) *Positive:* Accepted (G), respected (G), open (G), controlling (influential; G), self-controlled (G), self-confident (G)
Wife	4	Be understood (G), accepted (G), be helped (given support; G), avoid conflict (G), oppose (resist domination)/ have control (have things my own way)/ not be responsible/obliged (be free, not be constrained; G), be liked (G), be open (T)	*Negative*: Not understanding (G), does not like me (not truly interested in me; G) Positive: Loves me (G), helpful	*Negative*: Uncertain (G), dependent (G), not open (G), disappointed (G), anxious (worried, nervous; G), angry [not expressed; G] *Positive*: Independent (G), loved (G)
Sarah	3	Be accepted (not be judged; G), be liked (G), have self-control (G), feel good about myself/ comfortable (G), be my own person/ not be responsible/obliged (G)	*Positive*: Likes me (interested in me; G), open (G), accepting (G), cooperative (G)	*Positive*: Comfortable (G), independent (G), accepted (G), respected (G), like her (G), happy (G), open (G) *Negative*: Uncertain (ambivalent; G), don't understand (confused, poor self-understanding; G), symptom: back pain, tinnitus (T)
Across all interactions	10	Be accepted (G), be liked (T), avoid conflict (T), oppose/have control (T), not be responsible/obliged (T), be my own person (T)	*Negative:* Not understanding (T), does not like me (T) *Positive* Loves me (T), helpful (T) [Sarah + work]: accepting (T)	*Negative:* Uncertain (T), anxious (T), dependent (T), not open (T), angry [not expressed; T), disappointed (T) *Positive:* [Sarah + work]: accepted (T), respected (T), open (T)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); W's, RO's, RS's are ranked from most to least frequent; Wordings between brackets refer to 'Standard category components' within the precursory 'Standard category'.

Table 4
Patient's wishes (W), responses of other (RO), and responses of self (RS) in therapy sessions 83, 84, 86 and 87

Target of interaction	#	W	RO	RS
Mother	1	Be liked (G), be my own person (G), be helped (given support; G), avoid conflict (G)	*Negative:* Does not understand (G), distant (not truly interested in me/person/ interests; G) *Positive:* Loves me (G)	*Negative:* Not open (G), disappointed (G), angry (G)
Father	1	Be accepted (G), be respected (G), be helped (given support; G), be liked (truly interested; G), be my own person (not conform, G)	*Negative* Does not understand (G), does not like me (not interested in me; G), strong (G), not open (G)	*Negative:* Uncertain (G), anxious (G), disappointed (G), not open (inhibited; G)
Father in law	1	Have control (G), not be responsible/obliged (feel free/not constrained; G), assert myself (G), avoid conflict (G), be good (G)	*Negative:* Controlling (G), strong (G), not understanding (G)	*Negative:* Angry [not expressed; G], guilty (G), anxious (scared, nervous; G), not open (inhibited; G), dependent (G), oppose [passively, via symptom; G) *Positive:* Open (assert myself; G)
Wife	3	Be understood (G), accepted (G), be helped (given support; G), avoid conflict (G), oppose (resist domination)/ have control (have things my own way)/ not be responsible/obliged (be free, not be constrained; G), be liked (G), be open (T)	*Negative*: Not understanding (G), distant (not truly interested in me; G) *Positive:* Loves me (G)	*Negative*: Not open (G), dependent (G), disappointed (G), anxious (worried, nervous; G), dependent (G), angry (G), oppose [passively; G] *Positive:* Loved (G)
Boss	2	Have control (G), assert myself (G), be stable (have structure, security; G), be helped (given support; G), avoid conflict (G), achieve (G)	*Negative:* Strong (G), controlling (G) *Positive:* Accepting (G), respecting (G), gives independence (G)	*Negative:* Uncertain (G), anxious (G), not open (inhibited; G), headache (G) *Positive:* Accepted (G), respected (G), open (G), controlling (influential; G), self-controlled (G), self-confident (G)
Co-sportsmen	1	Be understood (G), be accepted (G), be liked (truly interested in me; G), be open (G), be opened up to (G), be close (G)	*Positive*: Understanding (G), accepting (G), like me (G)	*Positive:* Comfortable (G), happy (G), self-confident (G), accepted (G), like (G), open (G)
Audience musical performance	1	Be respected (G), achieve (G), feel good about myself (G), be close (G)	*Positive:* Respecting (value me, admire me; G), accepting (approve, include; G)	*Positive:* Accepted (G), respected (G), controlling (influential; G), self-confident (G) *Negative* Uncertain (G), symptom: tinnitus (G)
Across all interactions	10	Be accepted (G), be understood (T), be liked (T), avoid conflict (T), be my own person (T), have control (T)	*Negative:* Not understanding (T), distant (T), does not like me (not truly interested in me; G); controlling (T) *Positive:* [Work, co-sportsmen, audience]: accepting (T)	*Negative:* Not open (T), uncertain (T), anxious (T), disappointed, dependent (T), angry (T), oppose [passively; T] *Positive:* [Work, co-sportsmen, audience]: accepted (T)

Note. # = Number of events; G = General (occurred in all events); T = Typical (occurred in more than half of the events); V = Variant (occurred in at least 2 events); Wordings between brackets refer to 'Standard category components' within the precursory 'Standard category'; Therapy session 85 could not be used for CCRT-coding due to absence of audiotape.

Step 3: Associations between Symptomatic and Interpersonal Level

Analysis of Outcome Data. Longitudinal intra-subject correlations between IIP-32- and GHQ-12-scores document a significant positive association between the patient's interpersonal dynamics and his symptomatic/general well-being (r = .33, p < .01). However, longitudinal intra-subject correlations between IIP-32-scores, on the one hand, and SCL-90- and GAF-values, on the other, reflect (quasi) non-existent associations (r = -.10 with SCL-90, *ns*; r = .00 with GAF, *ns*), which might conceivably be due to the small number of measuring points (compared to the large number of GHQ-12 measuring points).

Qualitative Description of Association. *Preliminary note*: in referral to Luborsky's (1984) manual of supportive-expressive therapy, concrete therapeutic interventions are italicized, and designated as 'expressive technique' (RT) or 'supportive technique' (ST), including the related manual page. Literal wordings of patient and therapist are indicated by double quotation marks ("…").

Nick arrived for psychotherapeutic treatment with a well-formed goal in his mind. Following numerous consultations of his general health practitioner (GP) and an extensive diagnostic procedure at the University Hospital, he had a clear idea of the "objective", medically identified "damage" at his ears (tinnitus) and back (back pain) and currently wished, in accordance with the Hospital's referral, to work on the intensifying/accompanying "psychological component". From the beginning (and repeatedly throughout treatment), Nick illustrated the apparent presence of the latter in comparing himself to fellow tinnitus and back pain sufferers, e.g., "While you would expect the opposite, I appear to suffer least from tinnitus in quiet rooms or during night time"; back pain complaints proved minor to absent during/after heavy work-outs, but rose in all their glamour during the renovation work at his recently purchased house; newly prescribed antidepressants had instantaneous positive effects that, strangely, wore off after two weeks (i.e., "when they are actually supposed to start working"). He described how "the second crisis" of tinnitus (see Step 1) had coincided with the abrupt start of "severe panic attacks", and further explained it was not so much the pain as such that bothered him. In fact, both tinnitus and back pain "did not hurt at all", yet, served as "triggers" that "set in motion the radars in my head", which "intensified the initial complaints" and consequently caused panic to "spread uncontrollably".

Accordingly, he wished to be "armed against" this bothersome anxiety, and to specifically learn how to "attain control" over his "disastrous thoughts", so that he could peacefully "return" to his "prior state of living tranquilly with the objective damage". Therefore, Nick started every therapy session with communicating a daily overview of symptomatic appearances over the past week. In response, however, the therapist repeatedly involved him in self-expression, by inciting him to elaborate on the contextual embedment of these occurrences, to which Nick proved agreeable (even eager, e.g., during the diagnostic interview scheduled for the fifth session, he recurrently interjected standard

questions to embark upon personally relevant themes).

As such, Nick clarified he had always been “proud” of the so-called disco-tinnitus he had carried since a few years (see Step 1), as a result from the loud music he had long performed with his hard-core band. During the summer holidays before the onset of treatment, however, tinnitus had abruptly and inexplicably been charged with intense anxiety and guilt. Dissimilar to the years before, Nick had started to experience tinnitus as a source of “incessant worry" about "the consequences for the future”, and a motive to retrieve from all the bustling and the noise that accompanied the house renovations.

Asked to describe the concrete circumstances in which tinnitus had suddenly intensified (ST, p.87, p.89; ET, p.94, p.114), Nick “could only link it to one event”, i.e., *hearing* the news bulletin of a musician who had committed suicide due to unendurable tinnitus. At once, tinnitus had “assumed the meaning of something severe”. Nick had become intensely worried about “the seriousness of the condition” and the potential “far-reaching consequences it could have on someone’s life”. Incited to specify the nature of these (recurrently mentioned, but vaguely touched upon) “consequences” and “the future”, Nick disclosed intense fears of “being restricted in my functioning” and of “not being able to do certain things”. *Upon further incitement (ST, p.87, p.89)*, he appended that the week before contacting the therapist, he had visited a friend in the hospital, whose cancer “had nestled on his back and had paralyzed him completely”. Since then, “I have worried myself sick”, “brooding non-stop on all possible obstructive consequences”. *Asked to exemplify (ST, p.87, p.89)*, Nick clarified “I am constantly imagining myself becoming invalid, which would mean I would not be able to go to work anymore and pay for the loan for the house”, while adding irritably “the loan I am fixed to”.

Taking up this change in tone, the therapist invited Nick to articulate his pending thoughts and narrate about cited purchase (ST, p.87; ET, p.97). As such, Nick commented it was not him, but his wife, who had wanted to buy a house and start a family. He had wished to continue renting a residence and delay getting children, “because owing a house and having children corner you”, i.e., put an end to his “ability to spontaneously change directions in life” ("not that I would actually do so, but just the feeling of being able to”). He recounted how they had finally settled on buying a very old house that needed a lot of renovation work, “which means”, he added laughing, “that there is always something to worry about”. In fact, “with every single step I need to undertake, I am so absorbed in this worrying that it blocks me in actually doing what I need to do”, i.e., “I lose so much time by contemplating, or retrieving information, or seeking out everyone’s advice (while, actually, I already know beforehand what I need to do), that in the end I have done nothing”.

Stimulated to proceed on the theme of inhibition during the initial therapy sessions (ST, p.87, p.89; ET, p.114, p.131), Nick described how, during the days after having played music without earplugs, he constantly worried whether or not he might have caused further hearing damage. Whereas *not* playing music - but while working at the house instead - invariably aroused incessant

worry about additional back damage and a vague, destabilizing feeling of “having lost all control” over his life and future. *Not* working at the house, however, incited troubling feelings of guilt towards his wife and helpful father-in-law.

When the therapist subsequently pointed to notable similarities (ET, p.118, p.121) with Nick's previous descriptions of his father "as an anxious-prone person who endlessly dwells upon possible risks and negative consequences”, Nick dismally recounted he had never been supported or encouraged in any undertaking by his father, who had always advised *against* acting or shrugged him off by muttering “to do as I please”. And so Nick had done. From his early youth, he had been “a *passive* rebel”, never daring “to directly oppose or contradict my father”, but nevertheless, stubbornly proceeding his ambitions to attend music school and join a hard-core band. Though neither of his parents had ever supported his hobby decisions, they had never opposed him in carrying them out either; an ambiguously experienced freedom that was now forcedly drawn to a close. In eager response to *the therapist’s interested questions* (i.e., in marked contrast to the cited indifference of Nick’s parents; *ST, p.87, p.89*) with respect to this (recurrently mentioned, but thus far vaguely described) “profile”, Nick enthusiastically dwelled upon the accompanying philosophy, clothing and eating habits he had, as a spirited group member, identified with. More than the love for music, or his talents as a guitar player, his choice to join the hard-core sub-community had been fueled by the drive to assume the accompanying identity, and to “be part of” a group that “kicked conventional authority in the shins”.

After advancing a potential connection (ET, p.118, p.121) between this lack of desired support and Nick’s previously mentioned tendency to seek out others’ reassurance during renovation work, *the therapist inquired (ST, p.87, p.89; ET, p.121)* whether Nick ever encountered fears of provoking negative reactions when something would go wrong. Nick assented wholeheartedly and promptly paralleled this to his position at work. In marked contrast to the frequently described apathy, passivity and procrastination at home, Nick excelled there in “moving mountains of work”, yet, “only felt comfortable with working under the wings of a superior, who held final responsibility”. Moreover, “I would rather endure someone else stealing my glory than running the risk of being the one to blame when something goes wrong”.

Next, in session 5, Nick announced he had increasingly started to notice how “at home, I tend to *give up* much easier due to headaches or back pain, while in all the years I have worked at the school, I have never missed a single day because of sick leave”. For the first time articulating a dawning subjective implication in the creation of his symptoms, he explained how a vague, isolated feeling of “tension” and restlessness during the weekend had ignited “my back muscles to tense up”, “which is especially the case when I am alone at the house and I have time to think”. *Encouraged in verbally spitting out the sticky thoughts he had long been chewing on (ST, p.87, p.89)*, Nick explicitly began to voice some (long concealed) resentment towards his wife. He blamed her for having dragged him involuntarily into her wishes to buy a house and start a family (“which both *weigh* heavily on my

shoulders", i.e., the spot "where pain always originates before spreading out to my back"), and cursed himself for "not having put my foot down more assertively before it was too late".

During sessions 6 to 8, Nick praised how "talking things through" during sessions (i.e., "making connections, becoming increasingly aware of certain frustrations against my wife and fears of ending up like my father") made him feel "*lightened*" afterwards; which entailed a tangible decline in tinnitus and back pain complaints. *When directed to resume the theme of his father (ST, p.87, p.89; ET, p.131)*, Nick progressed "I have only recently fully acknowledged just how much I have always *bent over backwards* to not be like my father", i.e., "the pessimistic, frustrated, *back pain suffering* alcohol addict". "Which explains," he continued "the source of my anxiety to settle myself on something, e.g., on a house or a child, because that would only confirm I would be going the same, tamed way as him".

Following this relatively stable period (sessions 6 - 8), however, Nick low-spiritedly commented upon "a new upsurge of anxiety" in session 9, which had initially "nestled down" on his back and subsequently "moved" to tinnitus. Thereon, *the therapist reframed Nick's discouraging experience and heartened him* (*ST, p.83, p.87, p.89)* to "once again seize the opportunity to jointly work out the roots for this anxiety". As such, Nick disclosed that an MRI scan of his back had shown him that "everything was OK", "after which I ought to have been reassured". Yet, while reading the leaflet of a new type of antidepressants he had been prescribed by the GP to dim his anxiety, he had noticed tinnitus being listed as one of the possible side effects, whereupon his own tinnitus had instantly intensified. "It is like I always go *looking* for something," he said confusedly. "Whenever I feel anxious, I make a mental scan of my body and when I can't feel it hurting anywhere in particular, I go looking for a *reason* to associate the anxiety with. It gives me something to hold on to, as a matter of speaking." *At the therapist's incitement to proceed* (*ST, p.87, p.89)*, it suddenly dawned on Nick that "following the stable period after the first crisis" of tinnitus, "anxiety had resurfaced soon after I had *heard* for the first time I was to become a father". "I had not made the connection at the time," he continued spiritedly, "but now I notice the apparent parallel". In fact, "I had still been digesting the purchase of that house, when I had to endure that, as well," he sighed. *The therapist suggested (ET, p.94)* that "restlessness could possibly have been stirring inside you ever since this dubious purchase". Continuing that Nick might have "mirrored the habit" in his family of origin "to only communicate distress by means of physical ailments" *(ET, p.118, p.121)*, he advanced that "the *hearing* of this additional unwelcome news had probably contributed to the lingering tension, and had constituted the cue for the abrupt reappearance of tinnitus" *(ET, p.94, p.118)*. Interestedly underscoring this remark, Nick added that the concurrence of "all those responsibilities had dropped down like a hammer onto my *head*". He further reminisced how "the first crisis" had similarly broken through "during a very stressful period, in which my dog had given birth to a nest/litter of puppies", for which "I had felt immensely *responsible*". As he had deeply *cared* for these puppies, he had "put a lot of effort into finding them all secure homes to settle". *At the therapist's acknowledgment of this strain (ST, p.82)*, Nick affirmed he "had felt overwhelmed by immense *care*". Thereupon, *the therapist pointed to (ET, p.118)* the 'equivoque' apparent in Nick's narratives (i.e., an identically pronounced 'signifier' that potentially bears multiple

meanings) and *singled out (ET, p.118)* a number of pivotal signifiers, in saying that for Nick, the "*care* for" someone (e.g., caring for his future child or puppies) apparently equaled "bearing responsibility" for "taking *care* of" that person/creature, which installed "*cares*, worries" and accompanying "pressure". Nick answered in agreement that he currently felt "*burdened down* with worries about the house and that child" and that he deeply wished to be free from "*carrying* these burdens," while confessing he sometimes imagined himself "not being able to *carry* the child due to back pain". Additional metaphors appeared in session 11, when Nick leaked a brief increase of tinnitus over the past week, following a disturbing phone call of his mother (who had once again contacted him to complain about his father), which he had experienced "as a knock *on the head*". *Stimulated to expound on his feelings preceding tinnitus* (*ST, p.87, p.87; ET, p.94, p.114)*, Nick specified "I had actually felt a bit angry, but I instantly felt remorse about that". *When the therapist advanced the possibility* (*ST, p.87, p.87; ET, p.94, p.114)* that "tinnitus might have served the function of not having to *hear* her complaints", Nick appended he had indeed experienced it as "burdensome to have to listen to her troubles", as "I somehow perceive that, each time, she covertly asks me to stand up to my father in her defense". He, however, dreaded to assume the tight position she maneuvered him in. Though he had always refrained from explicitly telling her, he preferred to "avoid direct confrontation with my father". Simultaneously, he began, for the first time, to voice nuances in the former one-sided image of his mother: despite their "good bond", he had always encountered "a certain inhibition in speaking openly with her". "I have never felt totally at ease during contacts, which have always been centered on misery, complaints and physical ailments", and which bypassed discussion of his true passions, despite her own past as a prized accordion player.

During the following weeks (sessions 12 - 16), Nick claimed to feel much calmer and energetic, both at work and in contacts with his wife, towards whom he had assumed (to her overt delight) an opener stance. He explained this change as a substitution for former contacts with his mother, whom he had moved to the back seat in putting his wife in first place. Disclosing how "in this position, I perceive to stand much closer to my wife and future child", he now longed for his wife's comforting presence after busy work days, and expressed that his former anger and resentment towards her had diminished. "By realizing where my anxiety and burdensome thoughts originate from, I am more able to let them pass," he stated blissfully. Yet, he could still not account for remaining, vague feelings of anxiety and restlessness that always possessed him while being home; feelings that "only dim the moment I start occupying himself with something useful or valuable ". *At the therapist's signs of interest (ST, p.82, p.87, p.89)*, Nick disclosed about drives that inflamed him while working or playing music, i.e., "to create something, as a group, truly interacting with likeminded", "to develop my potentials, truly meaning something, contributing and being praised for that". *Stimulated to closely compare (ST, p.87, p.89; ET, p.118)* cited situations to the home front, Nick sharply contrasted these rousing experiences, to gloomy feelings of pointlessness and futility he encountered at home, where nothing but renovation work and family care awaited him, reminding him of his miserable father "who has never accomplished anything beyond that".

Next, the birth of his first child during the week preceding session 17, drastically re-aroused fears and backache complaints to “a breakpoint” (*tipping point 1)*. “One of the worst moments I have ever endured in my life,” he explained. Simultaneous caring for and resentment towards “the child”, coupled with unforeseen “obsessional ideas of hurting it” (e.g., “throwing it in the grate-fire”, “letting it drop”) had put him “completely off-balance”. In the same spate of words, he agitatedly proclaimed that “the child and the renovations induce restrictions for my future *and* aggravations of my complaints”. “Everything is centered on the child now,” he added agitatedly, “so in order to get better, it is crucial that I resume work and sports as soon as possible”. He vigorously underlined *the therapist’s identification of (ET, p.94, p.121)* “the *conflict* the child’s birth has awoken in you: on the one hand you wish to take care of it, out of love and affection; on the other, you fear this care will further curtail the realization of other desires and ambitions”. Further expressing unresolved difficulties in conjoining different identity parts, Nick added that “the role of father figure” also collided with his current “self-image of untamed, hard-core musician who rejects the mainstream, docile civil life” (as held out by his own father).

While Nick and the therapist *jointly explored and identified various facets of the pending conflict* (*ST, p.87, p.87; ET, p.94, p.114)* throughout the following sessions (sessions 18 - 24), Nick's well-being ameliorated again (to oscillate within bearable limits, see Figure 1). For the first time, he explicitly stated to perceive that “tinnitus and back pain as such are not the chief concerns”, but that “bigger issues are at stake”, e.g., “I *carry* the *burden* of the family more *on my neck*.” He then added laughing, “I used to invent the most frantic things to defer these matters, until my wife saw me through”. *Asked for concrete examples* (*ST, p.87, p.89)*, Nick illustrated “waiting until the windows had double-glazing, and afterwards the attic needed to be isolated, and so on”. When the therapist subsequently started to phrase “So you seized upon your symptoms as an excuse - ” (*ET, p.94, p.118)*, Nick completed promptly “for not having to work at the house, yes. Worries kept piling up in that period, until the bodily symptoms suddenly propped up as culprits that made the pile keel over. Especially the backaches functioned as *brakes* on continuing the renovation work. Similarly, the tinnitus allowed me to say ‘I’m sorry, fellows, I won’t be able to play today’”.

During these sessions (18 - 24), however, Nick reluctantly confided that longings to enjoy a comfortable, stable family life had grown considerably with age, but were incessantly “battled by” resisting urges to "go outside" and “prove” himself. *As the therapist singled out this remarkable choice for the word "battle" and further tied it to the image of aggressivity displayed in the ambitions Nick wished to pursue (e.g., hard-core band, kickboxing; ET, p.118)*, Nick proclaimed how these “unconventional hobby choices“ had indeed always given others (“even my mother”) the misleading impression “of a sturdy, powerful, undaunted person, while, on the inside, I am a totally different person”. After a short pause, he added hesitantly, “Thus far in therapy, I have repeatedly stressed that I habitually try to avoid conflict because I dread aggression, but actually I dread to fall from my pedestal, to scatter this fierce image, from the moment I am compelled to prove myself”. *Reminding Nick of previous disclosures (ET, p.118)* about his mother’s implicit longings “to put his father in his

right place", Nick underlined he had always "invented strategies that enabled me to avoid taking up a position of power or authority. Like my bodily symptoms, for example".

Next, Nick entered session 25 low-spiritedly, again reporting a brief upsurge of tinnitus. Following *therapeutic incitements to once again voice his concerns and reconstruct the context in which symptoms had risen* (*ST, p.87, p.87; ET, p.94, p.114)*, it turned out to have started soon after his head mistress had awarded him an additional task "that yielded extra authority". *As the therapist labeled the various circumstances in which tinnitus had surfaced thus far* (*ET, p.94, p.114, p.118)* as "situations of increased (psychic) *pressure*", Nick fingered the word 'pressure' as "a particular meaningful one" and appended thoughtfully he had also suffered from severe migraine (attacks) during those periods of increased pressure, "which, in fact, had always preceded the onset of tinnitus". Thereupon, *the therapist metaphorically compared tinnitus to* "the bodily release of psychic pressure, almost like steam" *and further concluded that (ET, p.94, p.114, p.118)* "tinnitus impedes you to continue those things to which you feel put under pressure". Consequently, throughout the following sessions (27 - 30), Nick began to re-articulate previously sketched circumstances - in which bodily complaints had overwhelmed him - in terms of "(situations of) pressure", e.g., his wife's pregnancy that had urgently forced the renovation progress to speed up after a (more harmonious) period of delay; the worries surrounding the *responsibility* of *taking care* of the persons he *cared* about, which often made him "avoid to get attached too easily to people"; the attention his mother demanded daily of him. When asked to phrase his motives for obediently responding to her intrusive demands, Nick reminisced numerous incidents in which his mother had "exploited her former, motherly care as a weapon to load me with guilt and the responsibility of equally returning the favor".

Synchronous with Nick's growing proficiency to voice itching worries, illuminate shadowed facets of pending conflicts, and articulate his subjective, multi-layered experiences of them, he became increasingly aware of his habitual (divergent) tendency to "*not* communicate hanging frustrations" to his wife, mother, or father, and increasingly situated the roots of his symptoms in this containment. Naming the latter as representatives of suppressed irritations, he phrased: "Because feelings remain inside, they manifest themselves in other symptoms, instead of speech".

In session 27, Nick announced that the headmistress had offered him the opportunity to apply for a new post in the school board, which he considered to be "a desired challenge" and a simultaneous "source of pressure", making it "a hard decision" whether or not to apply. As this situation had once again entailed temporarily intensified tinnitus, *the therapist newly invited Nick to explore and identify potential sources for this ambiguous pressure* (*ST, p.87, p.87; ET, p.94, p.114)*. Again *picking up on a metaphorical connotation* in Nick's enunciation (i.e., "Like the tinnitus reasoned 'Yes, I am still here, think about me when you want to make this step, I am *in your way*'"), *the therapist compared tinnitus to* (*ET, p.94, p.114)* "a personification, almost like a voice". Dismissing the suggested resemblance to his mother's voice, Nick expounded on his father's "acquired attitude of never taking any risks and abiding in safe, secure positions": "If I were to *listen* to what my father

would *literally say* (via my mother, though), it would be to 'stay where you are' and to 'not call that *pressure* of becoming a board member *onto your head'".* During the remainder of the session, Nick gradually articulated additional determinants for the current conflict, i.e., fondness of his current "intermediary position in between the students and the staff" ("I am a man of consensus", see also Step 2); "the image of dignified board member, dressed in costume, and delegating orders" that clashed with his "profile of tattooed musician". Thereon, the therapist located both described situations of "increased pressure" (i.e., inclining the position of board member and of father,) as "centered on embodying authority and responsibility"; in that way, conflicting with his "alternate stance of kicking conventional authority in the shins" (*ET, p.94, p.114, p.118)*. It was not until he had confided his pressing doubts in a fellow musician (who had enthusiastically encouraged him to pursue this ambition and "transform the conventional image" of a boring board member; i.e., instead of subduing that discording part of his identity), that Nick had felt encouraged enough to submit his application (session 29). Though he missed out on the job and had initially been very disappointed ("I had yearned to show my father it is very well possible to achieve things when stepping outside the box"), he had recovered rather quickly, and articulated in session 32 "the profound feeling that something has changed inside me", i.e., "I seem to have assumed a different, more mature way of thinking, and enjoy taking time to find my feet" (which is depicted in Figure 1 by an abrupt halt to the markable oscillations in his well-being between sessions 1 - 31).

From then on, Nick's struggle with the experienced nonconformity between diverging parts of his divided identity ("Who am I, really?" in this "collision between two totally different worlds") remained a central theme throughout the rest of the therapy (sessions 32 - 87). As various determinants of this pending conflict were weekly dragged into the therapeutic light (*ST, p.87, p.87; ET, p.94, p.114, p.118)*, cited foundations increasingly disentangled themselves from Nick's symptoms (e.g., "I used to *employ* these bodily symptoms as *a mode of transport* for suppressed feelings and pressure"), and (heretofore anxiety-rising) bodily expressions were progressively left into the shadows. Nick no longer started sessions with weekly reports of symptomatic fluctuations and, similarly, stopped addressing his mother and GP in a hunt for reassurance (reflected in the stable period of low IIP-32-dependency issues between sessions 46 - 60).

Moreover, perceiving *the therapist's expressions of interest* as cooperative, in a *regularly scheduled, joint search for understanding (ST, p.87, p.89),* Nick grew more involved in therapeutic work. He increasingly phrased the anxiety that long surrounded his bodily symptoms as "identical to the anxiety underlying the house and the child", i.e., "of not being able to break free from a chronic (never-ending) situation". More and more, he started to realize "just how much I have always (and still do) craved for my fathers' approval, recognition and genuine interest", and increasingly situated the roots for his occupational "urge to prove myself" within this experienced lack. *Upon the therapist's incitement (ST, p.87, p.89; session 34)*, he professed that "maybe one of the reasons I feel so inhibited with authority figures (e.g., at work) is my fear to show who I am, of being rejected, not being accepted, as my background differs from theirs". Correspondingly, the satisfaction he gained from "approving reactions of the audience" during music performances proved to originate from that same

lack. In marked contrast to previous disclosures of “finding peace and quiet” after busy work days “during the evenings, nestled down in the couch with my wife”, from session 34, Nick continually described home as a source of mounting restlessness (e.g., “not being able to sit still”, “restless legs, like tinnitus in the legs”) and persistent backaches. For, while tinnitus disappeared from his narratives, Nick started to disclose lucidly about backache manifestations, as conveniently interfering with renovation progress and childcare. Though he now recognized that, besides his current job position, “the purchase of that house was the only thing” that ever fell within the lines of his father’s silent approval, insisting fears of equally becoming “the pessimistic, anxious chunk of frustration” continued to maneuver him resistant towards “the conventional, domesticated life path”.

Prompted to elaborate anew (*ST, p.87, p.89; session 41)* on cited “frustrations”, Nicked avowed phantasies of “just dropping the kid with my wife while she is at work, and leave”. Picking up on his more overt expressions of resentment towards his wife (e.g. “lingering irritability”, occasional “aggressive outbursts”), Nick professed to become increasingly aware of unnerving feelings of “loss of control”, and “being subdued” to her “far-reaching” life decisions; which had always precedented (formerly puzzling) manifestations of back pain. For, latent aggression that hitherto manifested in passively opposing behavior, via his bodily symptoms, increasingly transformed into overt animosity towards his wife.

When the therapist subsequently inquired after Nick’s motives (*ST, p.87, p.89; ET, p.94, p.121)* for (though reluctantly) having indeed gone along with his wife’s wishes, Nick dwelled upon anxious concerns to have otherwise provoked relationship conflicts and disturbed interpersonal harmony. As previously touched upon during therapy, he recited deep-rooted wishes to avoid conflict as a common thread throughout relations with his wife, father and mother, and further linked it to his occupational talents as “intermediator” between students and staff. Profound wishes to be accepted and approved of recurrently spurred him to chew his tongue and bite back pressings words of displeasure that he, however, longed to discuss. Yet, as with his mother and father, he expected to hit a wall in “openly discussing matters” with his wife (though he had never actually initiated any discussion). Anticipating “no room for discussion”, he feared to be forced to either split up or abandon his untamed hard-core identity.

Thereon, Nick elaborated on his occupational drives to “give free rein to the person behind the student, his/her personal story, drives, ambitions and difficulties”, as repeatedly fueled by personally experienced deprivations (session 58). The recurrently experienced “lack of personal space” at home and destabilizing feelings of “being dragged onto a non-stoppable train” (especially after his wife’s second pregnancy), prompted Nick to increasingly retreat to work, “the only place I feel good” (sessions 61 - 87). Notably, instead of his bodily symptoms, he now “employed work as an excuse to flee from renovation work and childcare”.

Moreover, in session 74 (*tipping point 2)*, Nick shamefully confessed he had committed adultery. As a central theme throughout the following sessions (sessions 74 - 79), Nick gradually recognized that, “rather than love or sex”, he had “found with Sarah what I missed with my wife” (i.e., genuine interest, understanding and approval). To his own surprise, he experienced this short affair as “relieving”, a personal treat. Yet, unwilling to “give up what I have built this far with my wife”, he ended

his affair. Acknowledging that “my whole functioning is principally determined by a deep-rooted urge for recognition”, he settled with compensating for what he continued to miss at home by working, joining a sports club and resuming music performances. Ensuing feelings of confidence additionally prompted him to assume a more assertive stance towards “authority figures” at work, who finally “recognized” his hard work and prized him with a desired promotion. Yet, conflicts around embodying authority (at work) and loss of control (at home) continued to provoke “pressure”, migraine and restlessness throughout the remainder of therapy (which he broke off unannounced) and follow-up.

General Discussion and Conclusion

Starting from inconsistent findings in previous research on Blatt’s (1974, 2004) classical symptom specificity hypothesis, the present empirical case study aimed to contribute to *theory building* (through potential *hypothesis refinement*; Stiles, 2009) by documenting the dynamic evolutions between the patient’s interpersonal functioning and hysterical (conversion) symptoms throughout therapy.

In line with expectations, both (a) significant longitudinal intra-subject correlations and (b) extended qualitative analyses of patient’s narratives during sessions revealed *close associations* between his symptomatic and interpersonal level of functioning; i.e., symptoms clearly proved to be embedded in the patient’s current ways of relating to the desires of significant others (see below).

Further in line with expectations and in accordance with a preceding case study of a patient with hysterical symptoms (Chapter 4), self-reported interpersonal problems proved to be overall higher for the *dependent* than for the autonomous sub-profile. While autonomous issues remained low during the first half of therapy, dependent issues markedly fluctuated up to session 45. During that period, CCRT-analyses of narrated relationship episodes clarified profound longings to be reassured and comforted for his somatic complaints by significant others (especially his wife, mother, and general practitioner).

As symptoms gradually unraveled during therapy, and the patient started to assume different interpersonal positions towards his own longings and others’ desires, CCRT-wishes for reassurance and help steeply declined, while (frustrated) autonomous urges vigorously increased (reflected by notable increases in self-reported autonomous issues). Accordingly, further qualitative analyses of initial sessions revealed a number of elements that echo *autonomous* interpersonal mechanisms (e.g., Verhaeghe, 2004) and were not observed in cited previous case study, i.e., repeatedly addressed fears to be *restricted* by other people or factors (e.g., physical ailments) in future ambitions; longings to plot his *own* course in life; pathological *doubt*/worry, *inertia* and *aggressive outbursts* that particularly surfaced in those areas in which he felt *coerced* into boarding a train that had been fueled by others, and that curtailed personally desired strivings; in marked contrast to the high productivity, passion and result-orientedness in other domains.

Yet, extended analyses of later sessions illuminated the disquieting *conflict* the patient experienced between different parts of his identity he longed to reconcile into a *unitary sense of self* (i.e., typically *dependent* wish). Autonomous CCRT-wishes to 'be his own person', seemingly independent from other people, were actually rooted in similar underlying (*dependent*) dynamics to identify with alternate identity images between which the patient felt divided. Out of unfulfilled – though fiercely aimed – *dependent* wishes for recognition (see also Lind et al., 2014), approval, support and genuine interest from his alcohol-addicted and anxiously duty-bound father, the patient had turned away from the mainstream law-abiding suburban bliss, in seeking alliance with a sub-community of hard-core musicians that honored lifestyle images of unbound, non-alcoholic, opinionated members. Neither musical, sports nor professional ambitions were primarily directed towards achievement or competition (i.e., autonomous urges), but towards *alliance* with and *appreciation* from others (i.e., dependent longings).

This lifestyle image was unsettled, however, by (a) the pregnancy of his wife and the purchase of a house, and (b) career opportunities to occupy authority positions; both resembling the suburban bliss he had so proudly rebelled against. Deep-rooted (dependent) longings to *avoid conflict*, *maintain interpersonal harmony* (see also Blatt, 2008, p.177) and *attain others' approval*, generally 'coerced' him into *submissively giving in* to others' desires. Yet, symptoms arose exactly in those two areas: intense backaches at home 'allowed' him to slow up progress during house renovations, and prevented him to carry his children; while tinnitus during professional commitments 'installed' obstacles in climbing the social ladder. However, symptoms did *not* smooth the way for peacefully manifesting personally desired wishes, but put these to a halt as well: backaches 'blocked' both sports ambitions and head banging during concerts, while tinnitus impeded to play music. Hence, somatic symptoms proved to be (typically dependent) *'compromise formations'* (Freud, 1900 [1978]) that warranted the *simultaneous safekeeping and obstruction* of different sides of the conflict. Highly destabilizing conflict between various different identity parts or images were symptomatically 'resolved' by 'creating' bodily symptoms that postponed the (immediate) fulfillment of conflicting wishes. As such, symptoms temporarily safeguarded the patient from making burdensome decisions (cf. Freud, 1978 [1909d]); which were equally avoided by *additional (autonomous)* elements of endless pondering (i.e., pathological doubt) and inertia/inhibition (e.g., Vanheule, 2001). Fueled by phantasies of 'worst-case scenarios', conversion symptoms *symbolized* the determining interpersonal conflicts. This was manifested in significant *metaphors* that illustrate the figurative 'transcription' of vital, but 'unspoken' experiences onto the body (e.g., "The house and child weigh heavily on my shoulders", "The burden of the family rests upon my neck", "All those responsibilities fall like a hammer on my head", "There is so much pressure in my head that cannot escape").

The patient's 'choice' for a somatic (conversion) symptom can further be considered in light of Freud's notion of 'somatic compliance' (Freud, 1978 [1905e], p. 40-41), i.e., it is founded on the already present hearing and back damage, combined with the habitual tendency in his family of origin to express and deal with distress by means of bodily complaints (disengaged from any psychic attributions or determinants; see also Lind, Delmar & Nielsen, 2014).

In marked contrast to the latter, the therapist's repeated efforts to engage the patient in reflecting on and voicing latent emotions and thoughts (while equipping him with helping phrasings to put them into words; see also Lind et al., 2014) set in motion a process the patient willingly continued after therapy completion (as reported during the follow-up interview). As a result – and in contrast to initial experiences of his bodily symptoms as 'isolated' from his broader subjectivity – the patient increasingly started to appreciate and articulate his symptoms as *meaningful reactions* to perceived desires of significant others. This process progressively enlightened *miscellaneous determinants* of originally puzzling conflicts, which clearly showed that the symptoms' severity did not lie in the exact, measurable/quantifiable volume of the sound (tinnitus) or damage to the back (back aches), but in their *psychic load*.

During this process, start and evolutions in symptoms were alternately linked to different determining elements. Recurrent therapeutic focus on their underlying dynamics provoked initially solitary ties to *knot together* and revolve around *pivotal 'signifiers'*, some of which were provided by the therapist (e.g., "pressure", "care for/care of", "responsibility", "control", "recognition", "limitations", "powerlessness", "conflict", "choice"). This engendered the gradual construction of a *meaningful narrative*, escorted by remarkable *transformations* in the patient's speech: initially fragmented, dispassionate recitals of isolated symptomatic appearances and medical advices progressively made place for eloquent narratives in which symptoms were *situated* within broader contexts of the patient's subjectivity. As the multiple *functions* of these symptoms within the patient's singular way of positioning himself towards significant others progressively cleared, symptoms became *disentangled* from their various determinants; and the patient started to occupy *different interpersonal positions*, as an alternate means of living up to long-frustrated wishes in *non-symptomatic* ways. This observation proves consistent with findings from previous studies (e.g., Cornelis et al., 2016; Cornelis et al., under review; Grenyer & Luborsky, 1996; Luborsky & Crits-Christoph, 1998; Slonim, Shefler, Gvirsman, & Tishby, 2011), and corresponds to positive findings from large-scale studies on the efficacy of psychodynamic therapy (see recent reviews of Fonagy, 2015, and Leichsenring et al., 2015). Yet, in this patient, a satisfactory balance between dependent and autonomous strivings was not acquired at treatment end. Persistent interpersonal conflicts (embodied by his main CCRT) were not sufficiently 'worked through' during therapy (e.g., Verhaeghe, 2004) and continued to cause disquiet and (variably mounting) tension throughout follow-up. This is graphically depicted in Figures 1 and 3 by significantly decreased self-reported symptomatic problems (from treatment onset to follow-up), but slightly increased interpersonal issues, after significant improvements during therapy.

Conclusions

As predicted by the classical symptom specificity hypothesis (Blatt, 1974, 2004), and in accordance with psychodynamic theoretical underpinnings (e.g., Blatt, Freud, Lacan, Luborsky) and with previous findings (Chapter 4), quantitative and qualitative in-depth analyses of the longitudinal, dynamic interplay between symptomatic and interpersonal functioning indicate hysterical conversion

symptoms to be rooted in dependent behavior towards others. In line with expectations, therapeutic endeavors that targeted core dependent conflicts entailed interpersonal and subsequent symptomatic transformations.

Hence, at a conceptual level, findings are in line with observations from the previous case study on hysterical pathology (Chapter 4) in documenting the predicted dependent interpersonal mechanisms; yet, differ from the latter in observing a few additional autonomous elements (i.e., pathological doubt and inertia/inhibition), which, however, served the similar symptomatic purpose of postponing burdensome choices. In this sense, observations differ from the two previous case studies on obsessional pathology (Chapters 2 – 3) that illuminated profound interpersonal ambivalences between autonomous and dependent behavior[15].

At the methodological level, we conclude that empirical case research, in which extensive multiple method and multiple source data sets on one patient are examined, is paramount to address complex, clinical interplays between symptoms and interpersonal conflicts.

Limitations and Future Research Indications

The present study aimed to address several methodological limitations intrinsic to statistical hypothesis-testing research in cross-sectional group designs, in an effort to further enhance a rich understanding of symptom specificity. Accordingly, however, restrictions apply in statistical generalizability of the results to broader populations of hysterical neurotic subjects. Future empirical case research should therefore aim to (1) further contribute to *theory* building and potential hypothesis refinement (e.g., Stiles, 2015), and (2) enhance confidence in the *clinical* utility of the symptom specificity hypothesis, in shedding more light on converging and deviating findings on hysterical subjects. In particular, it would be valuable to contrast our observations to results from future (series of) longitudinal (single and multiple) case studies as to whether (dis)similar *patterns* can be found in underlying processes responsible for interpersonal and symptomatic alterations that led up to the discussed treatment outcome (see Iwakabe & Gazzola, 2009). In addition, quantitative-qualitative examinations of change processes occurring in psychotherapies from alternative treatment schools, grant the possibility of yielding (distinctive) observations that fail to correspond to the classical theory, thereby stimulating further theory improvements.

[15] These findings from the four empirical case studies (Chapters 2 – 5) are further addressed through systematic cross-case comparisons in the *General Discussion and Conclusions* (Chapter 6) of this doctoral dissertation.

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6

GENERAL DISCUSSION AND CONCLUSIONS

In the General Discussion of this doctoral dissertation, we present an overview and critical integration of the main findings from the four empirical case studies presented in Chapters 2 – 5. Each systematic case study detailedly substantiated longitudinal evolutions throughout supportive-expressive therapy in patients' symptomatology (Step 1) and interpersonal functioning (Step 2), as well as dynamic interplays between both levels, including therapist interventions and extra-therapeutic events impacting on this ongoing process (Step 3). In each Step, quantitative and qualitative data-analyses were examined and presented separately, and then critically integrated in the Discussion sections of each Chapter.

In this General Discussion, quantitative and qualitative findings from the hypothesis-driven and discovery-oriented parts of the four case studies are systematically juxtaposed and compared – both within, between and across the two pairs of similarly diagnosed patients[16] – to identify and articulate similarities, repeated observations and common themes, as well as significant differences, pertaining to manifest constructs and underlying dynamics (Iwakabe & Gazzola, 2009; Yin, 1994).

Through critical integration of con- and diverging findings, we indicate how these findings relate to the starting-point hypotheses presented in the General Introduction of this doctoral dissertation, and what our analyses of the four cases have additionally produced with respect to the project's discovery-oriented and theory-building aims. Conclusions are subsequently discussed in light of current theoretical and clinical knowledge and practice (Hanson, Creswell, Clark, Petska, & Creswell, 2005; Hill, 2012; Iwakabe & Gazzola, 2009). Finally, we address the project's strengths and limitations and advance how this research project can inform further examination of symptom specificity.

[16] Patients from case studies 1 – 2 (Chapters 2 – 3) met DSM-IV-TR (APA, 2000) criteria for Obsessive-Compulsive Disorder (axis I; no personality disorder was diagnosed on axis II). Based on Blatt (1974, 2004), they were consequently categorized as patients with "typically obsessional symptoms" (see General Introduction). Patients 3 – 4 (Chapters 4 – 5) met DSM-IV-TR criteria for Dissociative Identity Disorder (case 3) and Conversion Disorder (case 4), respectively. They were accordingly categorized as patients with "typically hysterical symptoms" (see General Introduction).

Overview and Critical Integration of Main Findings

Table 1 visualizes the present project's *overall research questions* based on Blatt's (1974, pp. 155-157) symptom specificity hypothesis and Luborsky's (1962, 1984) strongly related theory that (a) patients' symptoms are essentially rooted in maladaptive relationship patterns, underpinned by typical 'core conflicts'; and that (b) psychotherapeutic endeavours aiming at transforming these core conflicts will bring about interpersonal transformations, and subsequent symptomatic alterations (as previously evidenced by e.g., Grenyer and Luborsky, 1996; Luborsky and Crits-Christoph, 1998; Slonim, Shefler, Gvirsman, and Tishby, 2011).

Table 2 presents the project's operationalized translations of these overall research questions into *specific quantitative and qualitative predictions*, as tested in each of the four empirical case studies presented in Chapters 2 – 5 (i.e., with interpersonal functioning specifically operationalized in by means of CCRT-terminology; Luborksy & Crits-Christoph, 1998), followed by the main findings with respect to these predictions from each study.

In our discussion of these findings, progressive levels of abstraction will be attended. First, we address how concrete findings from the applied methods in each case study respond to the specific research predictions. Findings displayed in Table 2 will be addressed in two ways, i.e., row-wise and column-wise.

Examining the table rows, we note per case study on which points observations converge with (yield evidence for) symptom specificity as demarcated by Blatt (1974, 2004), and where findings significantly deviate from these theoretical statements. (Counter-)evidence from both the hypothesis-driven and discovery-oriented parts of each case study will be applied. We proceed by juxtaposing the main observations from the four studies, i.e., in contrasting the findings between, within and across pairs of similarly diagnosed patients; in order to identify (predicted and/or unexpected) communalities and discordances.

Addressing the table columns, we attend the separate operationalized components of the symptom specificity hypothesis, in order to determine whether, in the present project, particular components yielded more evidence than others, and whether significant differences in confirming versus refuting evidence can be noted between the four cases. Column-wise interpretation of Table 2 thus enables to identify specific areas of symptom specificity that are in need for potential refinement (i.e., modifications and/or extensions; Stiles, 2009, 2015) considering observed – but unexpected – complexities. On this point, observations are linked to conceivable interpretations in light of previous research and theoretical considerations.

Next, after synthesizing the documented (con- and diverging) observations across the four cases, we transfer the project's conclusions back to the initial symptom specificity hypothesis, in order to review whether findings prompt to suggest directions for refinement (i.e., "transferability" of findings pertaining to "analytical generalization"; Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005; Yin,

1994). Accordingly, in a last step, conclusions are tied to broader theoretical, clinical and methodological implications.

Table 1
Overall Research Questions with Respect to Patients' Symptomatic-Interpersonal Associations

Obsessional symptoms (Cases 1 – 2)	Hysterical symptoms (Cases 2 – 3)
Before the onset of therapy (during the intake phase) we expect symptoms will be accompanied by:	
Autonomous interpersonal style expressed in exaggerated emphasis on - definition of self as distinct from others - separation from others	Dependent interpersonal style expressed in exaggerated emphasis on - interpersonal relatedness - closeness to others
Throughout the therapeutic process, we expect:	
▪ SET will reduce patients' exaggerated strivings towards autonomy and independence from others, and their related expense or neglect of installing interpersonal relatedness ▪ Obsessional symptoms will subsequently diminish	▪ SET will reduce patients' exaggerated strivings towards interpersonal relatedness, and their related expense or neglect of developing a well-defined consolidated sense of self distinct from others ▪ Hysterical symptoms will subsequently diminish

Note. This table is a composited version of parts of Tables 3 and 4 in the General Introduction of this doctoral dissertation; SET = Supportive-Expressive Therapy (Luborsky, 1984).

Table 2
Specific Quantitative and Qualitative Predictions and Overview of Main Findings

	Before onset of therapy (during intake)		**Throughout therapeutic process**	
	Quantitative	**Qualitative**	**Quantitative**	**Qualitative**
Patient	**Predicted IIP-32 sub-profile?**	**Predicted CCRT-components?**	**Positive longitudinal intra-subject correlations between symptomatic/general and interpersonal functioning?**	**(1) Predicted changes in CCRT-components?** **(2) CCRT-transformations entailed symptomatic transformations?**
Case 1 *Obsessive-Compulsive Disorder* *Obsessional symptom*	*No*: Overall higher dependent profile throughout therapy and follow-up	*Yes*: Autonomous components across relationships *No*: Dependent components across relationships	*Yes*: (Medium-high) positive correlations	(1) *Yes*: Prevailing progression along dominant autonomous configuration: new sense of balance between autonomous (and dependent) W's, increased positive RO's and RS's (2) *Yes*: Increased non-symptomatic ways of living up to autonomous (and dependent) W's
Case 2 *Obsessive-Compulsive Disorder* *Obsessional symptom*	*No*: Overall higher dependent profile throughout therapy and follow-up	*Yes*: Autonomous components in relation to others *No*: Dependent components in relation to partner	*Yes*: (Medium) positive correlations	(1) *No*: In relation to partner: prevailing progression along dependent configuration: increased acceptance towards dependent W's, increased positive dependent RO's and RS's *Yes*: In relation to others: unchanged dominant autonomous CCRT, increased acceptance towards co-occurrence dependent – autonomous elements (2) *Yes*: Non-symptomatic ways of living up to dependent W's towards partner
Case 3 *Dissociative Identity Disorder* *Hysterical symptom*	*Yes*: Overall higher dependent profile throughout therapy and follow-up	*Yes*: Dependent components across relationships	*Yes*: (High) positive correlations	(1) *Yes*: Progression along dominant dependent configuration: increased positive dependent RO's and RS's (2) *Yes*: Increased non-symptomatic ways of living up to dependent W's
Case 4 *Conversion Disorder* *Hysterical symptom*	*Yes*: Overall higher dependent profile throughout therapy and follow-up	*Yes*: Prevailing dependent components + some autonomous components across relationships	*Yes*: (Medium) positive correlations	(1) *No*: Increased awareness of, but unchanged dependent conflicts (2) *No*: Symptomatic RS's continue

Note. Obsessive-Compulsive Disorder, Dissociative Identity Disorder and Conversion Disorder are diagnosed by means of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000); categorization of DSM-IV-TR diagnoses as typically obsessional or hysterical symptoms are based on Blatt (1974, 2004) and discussed in the General Introduction of this doctoral dissertation; IIP-32 = Inventory of Interpersonal Problems - 32 (Horowitz, Alden, Wiggins, & Pincus, 2000); CCRT = Core Conflictual Relationship Theme, W = Wish, RO = Response of Other, RS = Response of Self (Luborksy & Crits-Christoph, 1998).

Preliminary note. In discussions below, the four studied patients are respectively denoted (consistent with Table 2) as “case 1 (OS)” / “OS case 1”, “case 2 (OS)” / “OS case 2”, “case 3 (HS)” / “HS case 3”, and “case 4 (HS)” / “HS case 4”. “OS” refers to “Obsessional Symptom”, whereas “HS” denotes “Hysterical Symptom”. The “symptom specificity hypothesis” (Blatt, 1974, pp. 155-157) is abbreviated to “SSH”.

Row-Wise Interpretation of Table 2: Cross-Case Comparison of Main Findings

Cross-Case Comparison: HS Cases

When interpreting Table 2 row-wise, it is apparent that *confirming evidence* for the SSH proves *largest* in the cases with typically *hysterical* symptoms, compared to the cases with prototypical obsessional complaints: both HS patients mainly reported dependent interpersonal problems; their relational exchanges with others were markedly underlain by a typical, dependent “core conflict” (Luborsky & Crits-Christoph, 1998); and longitudinal intra-subject correlations between their symptomatic and interpersonal functioning proved (medium-highly) positive.

Yet, *only for case 3 (HS)*, evidence was found for *all* quantitative and qualitative predictions. In case 4 (HS), observations principally accorded with expected findings, except for two discrepancies:

First, although dependent interpersonal behavior prevailed in this patient, some elements could be discerned in his (narratives about) relational exchanges with others (both in CCRT-codings as extended qualitative analyses) that, *at first glance*, echo *autonomous* interpersonal mechanisms (e.g., Blatt, 1974, 2004, 2008; Verhaeghe, 2004) and that were not observed in case 3 (HS), e.g., longings to have control, to plot his “own” course in life, fears to be restricted by other people or factors in future life ambitions.

However, this observation does *not* necessarily *refute the SSH*. Blatt (1974, 2004) theorized personality development to be a dialectal process between relatedness as well as self-definitional dimensions – where normal (i.e., non-symptomatic) functioning is characterized by a synergetic balance between both, while pathological functioning is typically defined by an exaggerated emphasis on one of the two dimensions at the expense of a mature development on the other. Patients presenting typically hysterical symptoms are further theorized to mutually differ in the extent to which development on the autonomous dimension is impeded (or even neglected), depending on the particular position (from more primitive to more integrated) they occupy on the dependent dimensional continuum (Blatt, 2004, 2008). Hence, the SSH predicts dependent interpersonal behavior to prevail over, but in essence not exclude autonomous characteristics.

In *case 3 (HS)*, both quantitative and qualitative analyses underline the patient’s more *primitive (unilateral) stance* on the dependent continuum: his entire subjective functioning and sense of self is defined primarily (almost exclusively) in terms of interpersonal relatedness (e.g., Blatt, 1974, 2004, 2008); each and every relationship is directed towards fusion, closeness, giving and receiving love and affection; fulfillment of those wishes incited intense feelings of peace and happiness, while

frustration causes his whole well-being to plummet. Romantic engagements equaled agreeing with one another on everything, being constantly together, and sharing the same hobbies and circle of friends. The romantic break-up inciting a suicide attempt in mid-therapy left him vacuous, i.e., no longer knowing whom he was or how to fill his time. In contrast, in *case 4 (HS),* sense of self was more segregated from entire fusion with one other person (e.g., romantic partner), and identity issues covered a prominent place in his narratives; though (similar to dependent dynamics in case 3, but on a *more mature level*) unmistakably bound up with meaningful relations to prominent others (see below).

Hence, the observation of certain autonomous elements situated *within predominant* dependent dynamics in case 4 (HS), but not in case 3 (HS), does not intrinsically contradict the SSH as such, and has likewise been cited in other research as well (for a very recent contribution, see Werbart & Levander, 2016).

Moreover, qualitative analyses of case 4's narratives shed more light on the precise *nature* of these autonomous characteristics, and as such revealed a *meaningful distinctness* from according characteristics observed in *OS patients*. In case 4, two 'types' of autonomous characteristics could be discerned:

- The first type being *seemingly autonomous*, but in fact operating within the same *dependent* underlying dynamics, i.e., CCRT-wishes to "be my own person"[17] (i.e., seemingly independent from external influences) actually proved to be rooted in dependent strivings to *identify* with an alluring identity image that was different from the one valued by prominent others in his life. Relatedly, none of the "ambitions" he voiced were principally directed towards achievement or competition (i.e., intrinsic autonomous wishes, as observed in OS cases 1 – 2), but towards *alliance* and a shared meaning of identity by others within the same subculture (e.g., shared clothing habits, dietary lifestyle, philosophical ideas).

  Qualitative analyses shed light on the disquieting conflict (i.e., sense of subjective division/partition) case 4 (HS) experienced between those different "parts" of his identity. In line with *dependent* dynamics (e.g., Verhaeghe, 2004, p.375), he endeavored to answer opposing desires of various others in trying to *condensate* conflicting contents and experienced incompatibilities into *one, unitary sense of self.* As further addressed below, this typically dependent "compromising" inclination is in marked contrast with cases 1 – 2 (OS), who *assumed* the *co-existence* of diverging elements as *equally inherent, segregated* parts of their identity;

[17] Quotation marks throughout the text indicate referral to patients' own words. In the present project, patients' literal wordings – representing their own account of inner experiences – is deemed meaningful in light of further addressed remarks concerning profound limitations of (researcher-based) predefined item contents of self-report questionnaires. On an empirical and theory-building level, those limitations endanger the creation of a deformed picture (as previously advanced by Hill, Chui, and Baumann, 2013); on a clinical level, the potential "administratively created reality" (McLeod, 2011) might not coincide with patients' subjective experiences, which are, withal, the materials clinicians typically work with (Vanheule, 2009).

- The second type being *more fundamentally autonomous* (e.g., pathological doubt, inertia, inhibition; Vanheule, 2001), yet, additionally serving a *similar symptomatic function* of avoiding overt conflict and postponing burdensome choices between conflicting identity parts.

The second apparent discrepancy in HS case 4 (i.e., different from concrete SSH predictions visualized in Table 2 and from observations in HS case 3) refers to the *absence* of the predicted qualitative *transformations* throughout the therapeutic process. Yet – like the first discrepancy documented above – this observation does *not* necessarily *disprove the SSH* either, which predicted that, *if* therapeutic progression would occur, it would principally develop along the dependent dimension (see Table 1). As therapeutic gains simply remained absent (i.e., occurred neither on the dependent nor the autonomous dimension), case 4 did not yield explicit counter evidence for the SSH.

The absence of therapeutic progress was clearly visualized in the graphs depicting evolutions in case 4's self-reported symptomatic and interpersonal complaints (see Chapter 5) – which unremittingly oscillated throughout therapy and follow-up without notable improving trend – in pronounced contrast to remarkable progressions observed in HS case 3 (see Chapter 4).

Anew, qualitative analyses of the narrative material assembled throughout the ongoing therapy process shed clarifying light on operating evolutions, or, in this case, on *obstructions* in it. Presumably misled by the patient's recurrently uttered frustrations concerning his partner's dominating role in life changing decisions, and his related longings to pursue his – apparently "own" (see first remark above) – ambitions, the therapist had failed to identify patient's underlying *dependent* dynamics. Accordingly, *core conflicts* in patient's interpersonal functioning were *misrecognized* (i.e., not identified or attended to) and not sufficiently 'worked-through' during therapy (which is, however, in psychodynamic practice generally advanced to be the principal dynamo of change, e.g., Blatt, 1974, 2008; Luborsky, 1984; Vanheule, 2014; Verhaeghe, 2004). Analyses revealed that the only change to have occurred, resided on the level of *increased self-understanding*[18]. Core interpersonal conflicts endured and follow-up narratives illustrated how the persisting symptoms remained deeply anchored in them.

[18] I.e., increased awareness that his symptoms always arose in those interpersonal contexts in which display of one identity part was (in patient's own words) "involuntarily" curtailed by "unwished-for" overweight of the other. Though the patient had progressively acknowledged to be mainly curtailed by his own compromising drive to avoid overt conflict rather than by actual coercion of others, at treatment termination, he was still caught or "stuck" in this prevailing *compromising* inclination (which additionally remained the principal topic during the follow-up interview two years after treatment termination).
This observation contrasts with previous empirical evidence that gains in self-understanding are related to successful outcome in psychodynamic therapy (e.g., Crits-Christoph et al., 2013), but does conform to elaborate (theoretically and empirically grounded) argumentation of the psychodynamic author Fink (2014), who argues throughout two book volumes (entitled "Against Understanding") that conscious knowledge about symptoms and behavior patterns often thwarts rather than fosters clinical change (which he advances to require ongoing access to – and extensive work with – the unconscious).

Hence, *similar* to findings from previous studies applying the CCRT-method to examine dependency-autonomy characteristics (e.g., Crits-Christoph & Luborsky, 1990; Luborsky & Crits-Christoph, 1998; Vinnars, Dixon, & Barber, 2013; Werbart & Levander, 2016; Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004) and *similar* to observations from case 3 (HS) and cases 1 – 2 (OS), the main CCRT-theme of case 4 (HS) had not disappeared or altered substantially after therapy, but the patient had developed a capacity to recognize core conflicts. Yet, *dissimilar* to cited observations, case 4 (HS) had not succeeded in dealing with them in more flexible ways.

In marked contrast, *case 3 (HS)* showed *significant therapeutic progression* in all predicted areas, which was maintained three and a half years after treatment termination (i.e., in accordance with findings from large-scale studies on the efficacy of psychodynamic therapy; for recent reviews, see Fonagy, 2015; Leichsenring et al., 2015). Highly pronounced dependency issues dominated case 3's narratives and were additionally clearly manifested in his relationship to the therapist. Relatedly, core dependent conflicts were both identified and sufficiently "worked through" via a *strong working alliance*. Consistent with findings from previous studies (e.g., Luyten & Blatt, 2013; Luyten, Blatt, & Mayes, 2012; Werbart & Levander, 2016) and from cases 1 – 2 (OS), the therapeutic relationship *added new interpersonal experiences* that contributed to patients' development of a more mature way of relating to others[19], which subsequently entailed profound symptomatic transformations (as previously evidenced by e.g., Grenyer & Luborsky, 1996; Luborsky & Crits-Christoph, 1998; and Slonim, Shefler, Gvirsman, & Tishby, 2011), and which underlines the "crucial role of the therapist in facilitating clinical change" (Blatt, 2008, p.262).

Conclusions With Respect To HS Cases

To sum up, observations from HS cases 3 – 4 *largely accord* to predicted findings based on the *SSH*. In case 4 (HS), two discrepancies were observed that did not entirely coincide with concrete SSH predictions as visualized in Table 2, and which were not observed in case 3 (HS). Yet, as documented above, these findings did not intrinsically contradict or disprove the SSH as such.

Despite *differences* in overt phenomenological symptomatology (i.e., DSM-IV-TR diagnoses of Dissociative Identity Disorder in case 3; Conversion Disorder in case 4)[20] and considering the

[19] I.e., in HS case 3: less directed towards fusion with his romantic partner; a marked widening of his social world (more, satisfying friendships); a self-declared progression "from black-and-white towards more balanced relations with others".
In OS cases 1 – 2: less directed towards separation and distance from significant others (i.e., principally the romantic partner and, in case 1, family of origin); a decreased need to be in control and related increased involvement of the romantic partner in daily decision making; less ambivalent (see further) in relating towards the partner.
These observations are in line with previous empirical documentation that positive changes in personal relationships pertained to the family (present and/or of origin) in OS patients, while mainly to friendships in HS patients (Werbart & Levander, 2016).

[20] The present project's observation of different symptomatic expressions of similar underlying dynamics in HS cases 3 – 4, resulting in different DSM-IV-TR diagnoses, in contrast to similar DSM labels in OS patients 1 – 2 (i.e., Obsessive-Compulsive Disorder), is in line with psychodynamic

inherently-idiosyncratic contexts in which symptoms manifested, marked *similarities* between HS cases 3 – 4 surfaced in type of *underlying core conflict* (i.e., pivoted round *dependent* interpersonal issues), and in typical *mechanisms to defend* against these conflicts, which gave rise to *typically hysterical symptom constructions* (i.e., as 'compromise formations'; Verhaeghe, 2004, p.375-376).

Misrecognition of prevailing dependent dynamics impeded therapy progress in case 4 (HS), while adequate identification and working-through of dependent conflicts entailed pronounced, enduring improvement in case 3 (HS); which substantiates Luborsky's (1984) theses concerning SET treatment orientations, and Blatt's (1974, 2004, 2008) theory from which the SSH originated.

Cross-Case Comparison: HS – OS Cases

Then, further in line with the SSH and with broader psychodynamic theories (e.g., Blatt, 2004, 2008; Vanheule, 2014; Verhaeghe, 2004), *dependent* dynamics in both HS patients were *meaningfully distinguishable* from *dissimilar* structural dynamics (i.e., typical core conflicts, defence mechanisms and reaction formations) observed in both OS patients (cases 1 – 2).

Foremost, similar to HS patients, and in line with SSH predictions, both quantitative and qualitative analyses of the research material showed OS patients' symptoms to be intrinsically interwoven with their interpersonal functioning within meaningful social interactions (i.e., symptoms always arose within particular interpersonal contexts).

Yet, *which* social interactions counted as "*meaningful*" – and functioned accordingly as context in which obsessional versus hysterical symptoms arose – significantly *differed* between HS and OS patients, as previously documented by Werbart and Levander (2016), and as frequently commented upon in psychodynamic theory (e.g., Blatt, 1974, 2004, 2008; Verhaeghe, 2004). In OS cases, symptoms arose solely within *intimate family ties*, i.e., (for both cases) within the relationships with their romantic partner, and (for case 1) also within relational ties with his best (and only) friend since childhood, and (to a lesser extent) with his mother. Subsequently, OS patients' narratives during sessions mainly circled around relational concerns within intimate ties; other people were seldom mentioned (let alone by name) or commented upon.

In contrast, both HS patients' social world proved much wider, i.e., characterized by *more* – and *more diverse* – *relationships*. Besides on valued family bonds (both present and of origin), HS patients' narratives also centred on multiple friendships, interactions with colleagues and more casual (but impressionable) encounters in the street[21]. Accordingly, HS patients' symptoms arose in – and

theory, which generally acknowledges obsessional neurosis to be characterized by less diversity than hysteria (e.g., Blatt, 2008; Merskey, 1995; Verhaeghe, 2004).
Both OS cases centred on obsessional ideas or thoughts: particularly manifested in case 1 in the form of intrusive images of aggressive "scenes"; in case 2 specifically focused on rigid, fearful beliefs of immanent heart failure. Case 2's focus on bodily concerns is further addressed below in the discussion section on the status of dependency and care seeking in OS (compared to HS) patients.

[21] Notice how this is reflected in CCRT-tables of HS cases 3 – 4 (see Chapters 4 – 5), which are notably more elaborate than CCRT-tables of OS cases 1 – 2 (see Chapters 2 – 3). Tables contain

'shifted' more flexibly between (see Verhaeghe, 2004, p.375-376) – several interpersonal contexts, in which a wider variety of people were involved (compared to OS patients)[22].

Next, *dissimilar* to HS cases and *in contrast to SSH predictions*:

- Self-report questionnaire scores showed both patients to report more dependent than autonomous relational concerns. In fact, comparing individual questionnaire scores across the four cases, OS patients reported *more dependency issues* than HS patients (as further remarked upon below);
- CCRT-coding unearthed both (predicted) autonomous as well as (unexpected) dependent components in both cases. In contrast to the remark on case 4 (HS) above, concerning the *subordinate* presence of autonomous elements (i.e., *within prevailing* dependent dynamics and essentially serving *similar* symptomatic functions), qualitative analyses in OS cases documented dependent relational concerns to *ambivalently alternate* the predicted *autonomous* ones, i.e., relieving one another in *antagonistic* fashion (e.g., Freud, 1978 [1909d]; Lachaud, 1995; Verhaeghe, 2004).

Below, the prevalence and nature of dependency issues in OS cases will be addressed – both in comparison to HS cases, as in mutual comparison – and subsequently framed within the notion of *interpersonal ambivalence*, which is generally described in psychodynamic theories as particularly characteristic for obsessional neurotic pathology (e.g., Blatt, 1974, 2004, 2008; Lachaud, 1995;

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more rows (i.e., wider variety of mentioned relationships) and more (diverse) CCRT-components (i.e., W, RO, RS), compared to CCRT-tables presented in OS cases, which are *notably more rigid* throughout therapy (i.e., tables pertaining to early, middle and late therapy sessions reflect the same intimate relationships).

[22] Importantly, this also manifested in patients' *stance towards the therapist*, and towards therapy more generally. Within sessions, HS patients *eagerly answered* therapist's questions concerning *interpersonal contexts*, and – from early treatment sessions onwards – readily shifted focus away from their consulting symptoms to *spontaneous elaboration* on relational themes.

OS patients only *reluctantly* responded to the therapist's incitements to disclose about the relational contexts surrounding their symptom manifestations, and principally returned to *strict focus* on (isolated) symptomatic oscillations.

HS patients (especially case 3) frequently *praised* the ongoing working alliance and resulting progress (in case 4 this mainly pertained to gained understanding of unearthed "linkages" between various contexts in which symptoms appeared); whereas OS patients repeatedly *complained* about the effort it cost them to engage in therapy, and *ended* treatment much *sooner* than HS patients (i.e., 22-23 sessions in OS cases – with a temporary pause in case 2 – versus 41 and 89 sessions in HS cases, respectively).

Outside therapy sessions, HS patients spoke *openly* about being in therapy; whereas OS case 2 only confided in his partner, and *shamefully* hid his therapeutic engagement for the outside world, and OS case 1 kept this involvement entirely to himself.

These observations are in line with theoretical statements (e.g., Blatt, 2008; Luborsky, 1984) and previous research observations (e.g., Blatt, Zuroff, Hawley, & Auerbach, 2010; Werbart & Levander, 2016) that – in addition to the fact that psychotherapy inherently is a dependency relationship – the explicit *relational* focus in SET (i.e., higher compared to classical psychoanalysis) suits HS patients better than OS patients (who generally value the explorative part of therapy).

Verhaeghe, 2004) and which compiles a controversial study subject in recent empirical investigations (e.g., Moritz, Niemeyer, Hottenrott, Schilling, & Spitzer, 2013; Moritz et al., 2009).

Prevalence and Nature of Dependency and Interpersonal Ambivalence in OS Cases

In an attempt to meaningfully structure and reduce the apparent wide variety of symptomatic expressions within the field of neurotic psychopathology (and specifically counterpoising the expanding number of isolated DSM- and ICD-diagnoses; see General Introduction), the SSH intended to identify and describe specific associations between distinctive types of neurotic symptoms and distinctive modes of interpersonal functioning[23].

Yet, contrary to SSH predictions, the first column of Table 2 shows that the (self-reported) *dependent interpersonal profile prevails in both HS and OS patients.*

Several possible explanations (that do not necessarily exclude one another) seem conceivable, as this (single, quantitative) observation does not automatically entail subversion of structural HS – OS distinctions as such (see below). Observed divergences from predicted findings, based on one single measurement, might point to *conceptual* shortcomings (which could prompt for refinement – modification and/or elaboration – of [that specific operationalized part of] the SSH) and/or might also be ascribed to methodological artifacts of the applied measurement (which may fail to comprehensively grasp the intended construct in [one or several of the] studied subjects; despite proven reliability and validity in grand-scale studies[24]). Thus, here proves the added value of triangulating data from various (quantitative and qualitative) sources within a team of researchers, as detailedly commented upon in the General Introduction of this doctoral dissertation (Jackson, Chui, & Hill, 2011; McLeod, 2013).

The observations in both OS cases from self-reports (i.e., prevailing dependent concerns) and from CCRT-analyses (i.e., presence of both autonomous and dependent relational behavior) contradict the anticipated predominance of separating interpersonal behavior in OS patients. At this point, however, *pertinent questions* arise as to the precise *nature* of these *dependency issues* in each of the four studied cases – and, accordingly, whether mutual similarities appear between HS cases, and/or between OS cases (and/or potentially between HS and OS cases), as well as significant differences between HS cases on the one hand, and OS cases on the other[25].

[23] Use of the word 'meaningful' refers to the notion that – when coupled with distinctively influential factors (e.g., distinctive sensitivity to particular therapist interventions or treatment structures) – a theoretically grounded and empirically sound diagnostic distinction would then be able to guide clinical practices and lay out constructive treatment pathways or directions.

[24] See Method sections of Chapters 2 – 5 for psychometric properties of the applied Inventory of Interpersonal Problems - 32 (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000).

[25] For instance, one might ask: dependent of *what/whom* and *in what way? What kind(s)* of dependency issues are reported? *How* are these issues *experienced* and *what particular aspects* are

To meet these questions, findings from (context-independent, pre-formulated) questionnaire items and (standardized) CCRT-categories need to be extended with qualitative analyses of patients' narratives (as addressed below), since this grants the opportunity to identify operating factors that can shed new light and add to further clarification of current observations.

For, based on questionnaire scores alone, we have no means of knowing *how* patients *subjectively interpreted* the *predefined items* they assigned scores to (e.g., whom they were picturing or thinking of while reading the items pertaining to interpersonal experiences; whether or not this was the same person(s) for all items on the questionnaire; whether patients had specific [past or recent] encounters in mind, or rather general accounts of typical relational exchanges with [specific] others; whether these conceptualizations changed throughout therapy or in response to temporary, significant events; et cetera).

It seems feasible that HS and OS patients have interpreted the same questionnaire items *in distinctive ways***,** e.g., *in line with* longings and vulnerabilities central to their prevailing configuration (i.e., anaclitic/dependent or introjective/autonomous; Blatt, 1974)[26]; which has previously been advanced by Abela, McIntyre-Smith and Dechef (2003) as a plausible explanation for (part of) the inconsistency in findings from previous studies on the SSH. In other words, the *meanings* patients have attributed to the same concepts within predefined items could have been of a significantly different nature, yet, have resulted in equally high scores on those items. Hence, without patients' narratives, we have no words to interpret the numbers (see also Hill, Chui, & Baumann, 2013) and are consequently groping in the dark when faced with current findings. It has previously been asserted that a sole reliance on scores from outcome measures can produce an entirely deformed picture (Hill, Chui, & Baumann, 2013), or in fact "an administratively created reality" (McLeod, 2001).

As further discussed below, qualitative analyses of patients' narratives elucidated that:

- Dependency issues were indeed *highly prevalent* and *weighty* in the studied OS patients (despite the SSH's exclusive attribution to HS patients);
- The *nature* of these issues indeed *differed* importantly between OS and HS patients. Differences pertained to:

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sensed problematic? How do subjects *ascribe meaning* to the pre-formulated concepts in dependency-related questionnaire items?
As subjective experiences are the materials clinicians typically work with (Vanheule, 2009) and patients' engagement in psychotherapy can essentially be conceived as a dependency relationship (Werbart & Levander, 2016), pertinent consideration of how an individual patient experiences interpersonal dependency proves essential in fostering a constructive working alliance and fruitful treatment paths.

[26] For example: both dependent and autonomous subjects might report to suffer intensely from occupational failures. Questionnaire items on having failed to meet the required standards at work could conceivably be marked by *dependent* subjects as highly stressful events, due to interpretation in terms of a *feared rejection of love and approval*, or of *being expelled from a close group* of colleagues. *Autonomous* subjects might mark these same items as equally destabilizing, yet, resulting from achievement-related interpretations.

    - the *type of relationships* dependency issues emerged in (i.e., restricted to intimate relational bonds in OS cases, but omnipresent in all relationships for HS cases; as discussed above);
    - *how* dependency issues *manifested* in these relationships (i.e., ambivalently and antagonistically alternated with autonomous issues in OS cases, but not in HS cases).
- Dissimilarities between OS – HS cases could be conceived as *structural differences* with respect to the underlying drives that stimulated dependency manifestations; while idiosyncratic divergences (i.e., between HS cases and OS cases mutually) in concrete manifest expressions of underlying structures, could be understood through
    - the different *positions* (i.e., more primitive – more mature) patients occupied on their configurational dimension; in addition to
    - patients' inherently idiosyncratic contexts and life histories.

Firstly, OS patients mainly narrated about *struggles* pertaining to the fact *that* they felt dependent of someone other's love and attention *as such*, i.e., that they were not fully autonomous or self-reliant persons in the state of caring for someone (i.e., in case 2, for his partner; in case 1, for his partner, best mate and – to a lesser extent – mother), as this person had the power to influence them. They frequently disclosed to be (intensely) *ashamed* of this dependency, and had the tendency to disengage this relationship from their broader social world, e.g., by strictly *separating* the valued time spent with their partners from leisure outside, where they recounted to behave very differently (in marked contrast to HS patients, who liked to involve their partners in social activities and circle of friends). Both OS cases disclosed how dependent longings were *restricted* to these outlined relationships, which *contrasted sharply* to their habitual way of relating to other people. This was very pronounced in case 2 (who frequently discussed intense irritations towards others' intrusive interferences into his well-organized schedules, generally expressed in impatient, vindictive behavior), and also surfaced in case 1 (who was little concerned with other people apart from cited significant ones).

Accordingly, in both OS cases, symptoms had ("suddenly") arisen at a *significant starting point*, which had unexpectedly disrupted their long-established sense of self, i.e., the start of a romantic relationship (for case 1, his very first relationship; for case 2, for the first time with someone he truly and deeply cared about). This observation has recently been documented as a sudden breakthrough of dependent needs in predominantly autonomous subjects, whose obsessional *symptoms* were conceived to be unsuccessful attempts to introjectively *defend* against these dependent needs (Werbart & Levander, 2016). Correspondingly, in psychodynamic theory (e.g., Verhaeghe, 2004), obsessional symptoms are specified to be '*reaction formations'*, i.e., typically obsessional defense mechanisms against core conflicts. Every obsessional neurosis is described to contain an inherent hysterical foundation (e.g., Freud, 1978 [1909d]; Lachaud, 1995). In contrast to HS subjects, however, who typically tend to defend against core dependent conflicts by endeavoring to *unite* different sides of the conflict into symptomatic '*compromise formations'* (i.e., stimulated by their prevailing drive towards

unison; as documented above), OS patients are predisposed to construct reaction formations, in which conflicting sides are *isolated* from one another (i.e., incited by their predominant drive towards separation). As such, this *separation process* manifests at two levels, i.e., (1) in a prevailing need for interpersonal distance and autonomy from others, yet, always accompanied by (2) ambivalent alternations with dependent longings and vulnerabilities, which relieve the autonomous ones in antagonistic fashion.[27]

OS cases 1 – 2 *differed* slightly in *concrete manifestations* of structurally operating interpersonal ambivalences. In OS case 2, ambivalence principally manifested in:

- a strict division *between* (1) his interpersonal stance towards all "other beings", on the one hand, and (2) interpersonally relating towards his partner, on the other;
- a marked (self-acknowledged) contrast *between* (1) prominent autonomous functioning towards others, accompanied by a well-defined, mature sense of self, on the one hand, and (2) a self-proclaimed "overly dependent" stance and "separation anxiety" towards his partner, characterized by rather primitive dependent dynamics (i.e., compulsively seeking her physical care and intimate affection, Blatt, 2008; see also Merskey, 1995).

Yet, less pronounced, ambivalence additionally manifested *within* the relationship with his partner. Qualitative analyses of patient's narratives revealed his symptom to primarily function as a means of *addressing* her (physical) presence and undivided attention, yet, always immediately followed by the opposite motion of *installing a safe barrier* to counter his rising intrusion anxiety (e.g., Verhaeghe, 2004), manifested on two levels: (a) he angrily refuses her troublesome requests to share his inner thoughts and feelings (both at those specific moments as more generally), (b) in "choosing" for a symptom pertaining to immanent heart failure, he urgently calls for her immediate reassurance,

[27] Interestingly, here proves the scientific surplus value of psychodynamic theory from a Freudian-Lacanian orientation (e.g., as conceptualized by Verhaeghe, 2004), which grounds *overt* symptomatic and interpersonal behavioral *manifestations* in *structurally underlying drives* (i.e., principally directed towards unison and compromise, or mainly aimed at separation and isolation; see above) – in comparison to empirical studies that mainly focus on overt constructs and manifestations, in which apparently opposing findings are deemed inconsistent.
In this respect, empirical investigation into the interpersonal attitudes – mainly assessed via self-report questionnaires – and relational behavior of patients diagnosed with Obsessive-Compulsive Disorders (OCD), has yielded controversy between researchers. Moritz, Niemeyer, Hottenrott, Schilling, and Spitzer (2013) pointed to disputes between cognitive-behavioral researchers, on the one hand, who frequently observed exaggerated *pro*-social interpersonal behavior (e.g., inflated responsibility and worry for — especially significant — others), and psychodynamically oriented researchers, on the other, who additionally fingered so-called *anti*-social attitudes (e.g., latent aggression and hostility towards others). As described above, from a *structural* (Freudian-Lacanian; see Verhaeghe, 2004) point of view, *both* pro- and anti-social behaviors are recognized to be *underlain* by the *same* separation process that is dominant in OS (or OCD) patients.
Particularly relevant to the present doctoral research project: in response to cited controversy, Moritz et al. (2013) raised the *need for future investigation* into the *functional links* between the seemingly opposing interpersonal styles. Moritz et al. (2009) specifically recommended *thorough, in-depth investigation* into *latent dynamic underpinnings* that contribute to social "façades", since "consideration of these concealed attitudes in therapy may prove beneficial" (p.288).

but obstructs her to ultimately succeed in this "function", as he considered her own father to embody the fundamental that a perfectly healthy man can suddenly die of heart failure.

In OS case 1, on the other hand, interpersonal ambivalence mainly manifested in:

- alternations *between* choosing for his girlfriend, at one time, then choosing for his best mate, at others;
- alternations *between* love and hate *within* each of the two opponent relationships.

In contrast to OS case 2:

- dependent longings (within both relationships) were less primitive and more mature (Blatt, 2008), i.e., more centered on intimate love and sharing affection rather than physical care and reassurance;
- autonomous components were less developed at the onset of treatment, but matured profoundly throughout therapy. After 'working-through' ambivalent experiences (especially feelings of being "stuck" in opposing – mutually immobilizing – tendencies; e.g., Blatt, 2008; Vanheule, 2001; Verhaeghe, 2004), pronounced *progression* occurred along the predicted *autonomous dimension* (expressed in increasingly fulfilling achievement-oriented, competitive, self-assertive behavior, and more mature self-definitional efforts and ambitions), which is in line with previous research findings (e.g., Blatt & Auerbach, 2003).

Similarly, in OS case 2, therapeutic *progression* also occurred along the predicted *autonomous configuration*, yet, not in the sense of more maturely developing autonomous components (i.e., autonomous behavior and a well-outlined sense of self in relation to others – which he had never experienced as problematic – remained unchanged), but in the sense of working-through interpersonal ambivalences (though, for case 2, only within the relation to his partner).

In both OS cases, tension-laden ambivalences diminished by *assuming* the *co-existence* of (initially battled) dependent longings and (proudly paraded) autonomous characteristics, as *two inherent parts* of their identity[28]. According to expectations, weakened ambivalences were subsequently mirrored by fading symptomatology (e.g., Grenyer & Luborsky, 1996; Luborsky & Crits-Christoph, 1998; Slonim, Shefler, Gvirsman, & Tishby, 2011)[29].

[28] In other words: as two conflicting parts, dependent and autonomous dynamics were initially isolated (e.g., expressed in particular symptomatic alternations) and gradually harmonized into a peaceful juxtaposition of both parts within a newly defined sense of self.
In marked contrast (and as documented above), in HS subjects, co-existence of diverging parts (resulting from their prevailing drive to meet differing desires of various others) entails intolerable feelings of incompatibility (defended against by means of compromising – symptomatic – endeavours).
[29] Noticeably, this finding did not translate into a decreased dependent sub-profile as self-reported on the Inventory of Interpersonal problems - 32 (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000) at the end of treatment. Several explanations seem feasible. For instance, both OS patients ended therapy promptly after having reached this newly constructed sense of self and related symptom remission. Possibly, (deeper-rooted) conflicts were not sufficiently worked-through during therapy. In this respect,

Next, according to expectations: in contrast to marked self-definitional endeavors in both OS cases (i.e., developing a consolidated sense of self in contrast and competition with other people, whom they proudly want to outstrip in skill, both in occupational and leisure activities), *autonomous* longings proved *much less* pronounced in *HS subjects* (who were mainly concerned with installing a sense of alliance with – a wide variety of – others in cooperating towards mutual goals, and defined their sense of self primarily in terms of this interpersonal relatedness). Accordingly, interpersonal ambivalences were not observed.

Further in contrast to OS cases, dependency issues did not pertain to the fact of feeling dependent as such (see above), nor did they entail feelings of shame. Instead, feelings of *disappointment, anger, blame* and *guilt* mainly arose around issues pertaining to *not being able* to *give* and *receive* love, acceptance and affection as much as they wanted to. As documented above, HS patients' interpersonal functioning mainly centered on *trying to please (many different) others*[30].

In marked contrast, OS patients never spoke in terms of what (significant) others might desire from them. In those relationships in which dependency issues surfaced, they were rather *egocentrically focused* on the *receiving* end of desired care and love[31].

Cross-Case Comparison Conclusions

To wrap up the findings (based on row-wise interpretation of Table 2) in a nutshell: evidence for the SSH proved largest in HS patients: in case 3 (HS), observations conformed to all expected

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Werbart and Levander (2016) – comparing therapy gains in anaclitic/dependent and introjective/autonomous patients – stated that autonomous subjects, who typically tend to avoid being overly dependent, might use the therapist in the service of (mere) symptom change, without the deeper relatedness that is needed for (wider) personality change. Especially in OS case 2, profound separating tendencies towards others notably transferred to the relationship with the therapist (see Chapter 3).
In addition, during *the follow-up period* after treatment termination in OS case 2, a slight *decreasing* trend is noticeable in the IIP-32 *dependent* profile, accompanied by a slight *increasing* trend in the *autonomous* sub-profile; which is not observed in OS case 1. Yet, the follow-up period in case 2 compiled +/- 3 years (from treatment termination to last follow-up assessment), compared to a notable shorter period of +/- 6 months in case 1. It seems feasible that consolidation of therapy gains requires some time, as has previously been advanced in large-scale studies on outcome of psychodynamic therapies (for recent reviews, see Fonagy, 2015; Leichsenring et al., 2015) and as recently observed in research on therapeutic improvement in autonomous subjects (Werbart & Levander, 2016). However, the observed quantitative trends might also reflect methodological artifacts or patients' momentary states, as case 2 only yielded one follow-up measurement after treatment termination (hence, the de-/increasing trends are merely based on two measurement points). As already commented upon, prudence is called for when interpreting individual scores from predefined questionnaire items. Other explanations (e.g., conceptual and/or methodological considerations) might be applicable as well.

[30] Observed differences in idiosyncratic expressions of dependency problems between HS patients have been addressed above, as understood through Blatt's (1974, 2004, 2008) statements concerning more primitive – more mature positions on the dependent/anaclitic dimension.

[31] This "self-centeredness" has previously been described by Merskey (1995).

findings; in case 4 (HS), elements were observed that did not entirely coincide with concrete SSH predictions as visualized in Table 2 and that were not observed in case 3 (HS), but which did not intrinsically contradict or disprove the SSH as such.

In contrast, in OS patients, elements did appear that could not easily be reconciled with the SSH, yet, which were in accordance with broader theoretical claims from which the SSH is deduced (Blatt, 1974, 2004, 2008), with Freudian-Lacanian psychoanalytic theory (e.g., Verhaeghe, 2004), and which related interestingly to previous research findings.

Framed within this theoretical and empirical groundwork, the argumentations we advanced above centralize into the following conclusions (which will further be addressed below). Despite *idiosyncratic differences* in concrete symptomatic and interpersonal manifestations between the four subjects under study, *similar underlying dynamics* could be observed in HS subjects, on the one hand, and OS subjects, on the other.

HS subjects were structurally similar in their prevailing drive towards fusion and compromise; while OS patients were interrelated with respect to predominance of the separation drive. More specifically, (in line with psychodynamic theory, e.g., Verhaeghe, 2004):

- OS cases 1 – 2: obsessional symptoms (as reaction formations) typically coincided with prevailing interpersonal inclinations towards *isolation* and *autonomy* – yet always accompanied by the characteristic *ambivalence* – via predominance of the underlying *separation* process;
- HS cases 3 – 4: hysterical symptoms (as compromise formations) were characteristically associated with typical interpersonal tendencies towards *unison* and *love*, via a predominance of the structurally underlying *unifying* process.

Prevalence and Nature of Bodily Phenomena in HS – OS Cases

Before presenting a concise overview of findings from column-wise interpretation of Table 2 in the next section, and subsequently proceeding to a critical discussion of how the documented findings from cross-case comparison can be transferred to the SSH, we succinctly comment upon the theme of somatic phenomena in neurotic psychopathology.

The SSH specifically associates (psycho)somatic symptoms to dependent interpersonal functioning (e.g., Blatt, 1974, 2004). In the present project, however, bodily phenomena were not only observed in HS case 4 (DSM-IV-TR Conversion Disorder; centered on tinnitus and back pain complaints), but also in OS case 2 (DSM-IV-TR Obsessive-Compulsive Disorder; centered on obsessional thoughts and related anxiety pertaining to immanent heart failure). Yet, based on meaningful distinctions in the nature of these bodily phenomena – understood through the discussion of structural dynamics presented above – these findings do not fundamentally contradict the SSH.

Central in OS case 2 were intense fears (sometimes culminating into “panic attacks”) concerning his self-proclaimed “bodily symptoms”, which were his main focus of attention throughout the entire therapy. The patient disclosed to “obsessively monitor” his heart rate for abnormal rhythms,

which (initially daily) arose *obsessional thoughts* that he was in immediate danger of "suddenly *dying* of heart failure". In seek for reassurance and care, he each time *immediately addressed* his *partner*, who was the *only one* to know about these thoughts and fears (which he *masked* for "the *outside world*" out of shame). From its first occurrence until symptom remission, this scenario always repeated itself in exactly the same manner. Notably, patient's narratives always centered on "sudden death" resulting from heart failure; yet, *not once* in therapy had he narrated about pictured *consequences* of this death (e.g., what his death would mean to others; see also Merskey, 1995, p.194).

In marked contrast, the bodily symptoms observed in HS case 4 structurally comprised (typically hysterical) metaphorical symbolizations of underlying conflicts (see above). Instead of the isolated and rigid prevalence of OS case 2's symptoms within his romantic relationship, HS case 4's symptoms were *openly displayed* in the patient's *broader social world* and proved much more *liable/unstable* (e.g., Merskey, 1995, p.191; Verhaeghe, 2004, pp. 376-377), i.e., in trying to meet the varying demands of several others. In contrast to OS case 2, he *wore out medical doorsteps* with weekly consultations of his General Practitioner (in addition to a variety of medical experts, with each change in symptom manifestation). Moreover, in *accusing* various others for their ambiguous desires and weighty longings towards him, he greedily elaborated during therapy on the *manifold consequences* (for these desires of others) of the loss of the bodily functions presented in his symptoms (i.e., tinnitus, head and back aches; which typically comprised *detectable motor functions*; see Merskey, 1995, p.193).

Column-Wise Interpretation of Table 2: Specific SSH Components

Prior to a discussion of how integrated findings from cross-case comparison relate to the SSH, in particular, and to symptom specificity in the field of neurotic psychopathology, more broadly, we briefly[32] return to a column-wise interpretation of Table 2.

Columns visualize separate parts of the SSH as specifically operationalized and subsequently tested in each of the project's four case studies. Column-wise interpretation of findings thus enables to determine whether, in the present project, particular components yielded more evidence than others.

- The first observation that stands out is the overall confirmation for column 3, i.e., in all studied patients, positive correlations were observed between symptomatic and interpersonal levels of functioning throughout therapy and follow-up, both in quantitative (i.e., column 3) as in qualitative analyses of the materials – which is in line with predictions based on Blatt, 1974, 2004; and Luborsky, 1984; and according to broader psychodynamic theory, e.g., Verhaeghe, 2004);
- The second salient observation is the predominance in all patients of dependent interpersonal functioning (which was predicted by the SSH for HS, but not for OS patients) based on self-

[32] "Briefly", i.e., as the project's main findings have been substantiated in the row-wise interpretation of Table 2 presented above.

report questionnaire scores (i.e., column 1). Further, CCRT-analyses (i.e., column 2) of patients' narratives about interpersonal exchanges revealed an (expected) predominance of dependent characteristics in HS patients, and co-existence of (unpredicted) dependent and (predicted) autonomous aspects in OS patients. These findings (i.e., columns 1 and 2) have been critically addressed in the cross-case comparisons presented above;

- Additionally, as expected by Luborsky (1984), each patient's relational exchanges were underpinned by a typical core conflict (i.e., column 2), and targeting of these conflicts during Supportive-Expressive Therapy (SET; Luborsky, 1984) entailed interpersonal transformations, which were appended by subsequent symptomatic alterations (i.e., column 4; which has previously been evidenced by e.g., Grenyer and Luborsky, 1996; Luborsky and Crits-Christoph, 1998; Slonim, Shefler, Gvirsman, and Tishby, 2011). However, the nature and degree of change varied considerably between patients (i.e., column 4). As substantiated above, the nature of evolving structural dynamics throughout therapy accorded in all cases to predicted evolutions (or obstructions in it) along patients' predominant dependent/anaclitic or autonomous/self-definitional configuration (Blatt, 1974, 2004, 2008).

Theoretical and Clinical Implications

Theoretical Implications For Symptom Specificity In Neurotic Psychopathology

Above, we presented conclusions from cross-case comparisons of the project's main findings. On this point, we transfer these findings back to the starting-point SSH (Blatt, 1974, 2004, 2008), in particular, and symptom specificity in the field of neurotic psychopathology, more broadly.

As outlined in the General Introduction of this doctoral dissertation, an enriching contribution of systematically conducted, well-documented case studies – and their critical integration in a multiple case study (Yin, 2014) – lies in the 'analytical generalization' (Yin, 1994) and 'transferability' (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005) of grounded observations to theory-building (Stiles, 2009, 2015) and their clinical applicability (e.g., Flyvbjerg, 2006; Iwakabe, 2011; McLeod, 2013)[33].

Importantly, as pointed out above, the overall – theoretical and clinical – intention of the SSH was to identify and describe specific associations between particular types of neurotic symptoms and distinctive modes of interpersonal functioning. In an attempt to meaningfully structure and reduce the glaring variety of symptomatic manifestations within the field of neurotic psychopathology, the SSH endeavored to counterpoise the expanding number of isolated DSM- and ICD-diagnoses (see General Introduction).

[33] i.e., rather than in striving towards generalization of findings to broader populations or universes (i.e., to enumerate frequencies; referred to as "statistical generalization"), and relates to the notion of "analytical generalization" (Yin, 1994, pp.35-36).

In their eager gaze at *overtly manifested phenomenology*, clinicians working with DSM/ICD generally turn a deaf ear to *subjects' dynamic life stories*. Yet, in the present project, it was precisely this material (i.e., patients' narratives during sessions and consecutive data-analyses) that enabled to unearth *vital structural dynamics* in HS and OS patients' idiosyncratically expressed functioning. For – just as previous research on symptom specificity had yielded markedly inconsistent findings (see General Introduction) – overall examination of Table 2 bears mixed evidence pertaining to the SSH.

However, as recurrently substantiated above, we advance that *inconsistency* in observed findings only existed on the *level of manifest constructs* (i.e., overtly expressed symptomatic and interpersonal functioning), especially when (solely) assessed via patients' self-report on pre-defined questionnaire items and/or constrained into standardized CCRT-categories. Yet, when *underlying structural dynamics and drives* (i.e., giving rise to distinctive constructions on both levels) were taken into account, through extended qualitative analyses of patients' narratives, findings did *converge* with fundamental SSH statements. In the studied subjects, *characteristic* symptomatic and interpersonal functioning proved *structurally interrelated* by a *distinctive predominance* of the *separation* or *unifying drive* process.

Hence, based on the present project's findings, we propose that – when conceptualizing 'symptom specificity' in this structural sense – the overtly diversified field of neurotic psychopathology could indeed be understood as structurally underlain by specific symptom-interpersonal associations.

This structural conceptualization of symptom specificity can fundamentally be traced back in Blatt's broader psychodynamic theory (e.g., Blatt, 1974, 2004, 2008) from which the SSH originated. However, to tailor theoretical statements for systematic empirical investigation, nuanced accounts are essentially operationalized (and, in the same movement, inevitably reduced) into concretely testable statements.

Importantly, in its empirical translation of theoretical elaborations on the separation drive – in order to construct predictions concerning the distinctive interpersonal functioning related to obsessional symptoms – the SSH specifically *singled out* (of Blatt's broader bolstering theory) those statements on separation as *solely* manifested in relational tendencies towards *interpersonal distance* and *autonomy*; thereby disregarding the – equally characteristic – interpersonal *ambivalence* operating in obsessional dynamics.

Yet, as documented in OS cases studied in the present project, this prevailing need towards separation, does not literally translate into concrete relational exchanges that are directed towards autonomy from *all* others, or in *every* (significant) relationship at *all* times; nor does it invariably manifest in the same manner in OS subjects.

However, previous studies on the SSH (see General Introduction) all applied cross-sectional group designs and combined individually assigned scores on pre-defined questionnaire items into aggregated findings on static associations. Hence, constraint of participants' dynamic symptomatic and interpersonal functioning into (a) cited SSH operationalizations and – additionally – (b) these particular quantitative measurements of cited operationalizations, might conceivably have contributed

to observed inconsistencies in previous findings, both between participants in the same study, as between the different studies. As constraint on these two levels obscured underlying operating dynamics, previous studies had not been able to grasp the structural level on which subjects might indeed be distinctively grouped[34].

> *Hence, based on these conclusions, we advance a structural conceptualization of symptom specificity – i.e., targeting the structural dynamics that drive symptom formation as well as interpersonal functioning – thereby recognizing interpersonal ambivalence as intrinsic part of the separation drive pertaining to obsessional symptom formation – as favorable (i.e., theoretically more beneficial and clinically more applicable) to the current conceptualization of the SSH.*

This additionally points to the pivotal, practical importance of *psychodiagnostics* with a *sound basis* in a *bolstering clinical theory* (e.g., Blatt, 1974, 2004, 2008) – as elaborately argued by Vanheule (2014) and Verhaeghe (2004) – without which we have no means to meaningfully reduce the wide variety of overt symptomatic expressions within the field of neurotic pathology.

As such, generalization or transference of individual case findings to the level of *subgroup patterns* and *similarities* is indeed *worthwhile* and even desirable, when it proves able to meaningfully contribute to a more *comprehensive and nuanced understanding* of the phenomena under study (i.e., theoretical implication) and further enables to *constructively inform* (i.e., advance particular directions to tailor) concrete *clinical practices* (i.e., clinical applicability).

Clinical Implications

In the General Introduction of this doctoral dissertation, we started off by documenting the project's *'*social validity'[35] in addressing the rising dissatisfaction amongst clinicians and social science researchers concerning the present-day large amount of isolated diagnostic categories and the latter's limited clinical applicability (see Vanheule, 2014, for a comprehensive argumentation). In order for psychodiagnostics to become more effective (i.e., to better guide clinical practice and foster subjective change), we pointed to the need for meaningful reductions within the diversified field of neurotic symptoms, and fingered the SSH as a valuable attempt in this direction.

In our discussion of cross-case comparisons above, we provided substantiated argumentation that – in the four studied patients – neurotic psychopathology could indeed be understood as structurally underlain by specific symptom-interpersonal associations, and that rightly identifying and

[34] Again, we acknowledge that other possible factors might alternatively have contributed to observed inconsistencies, which makes further investigation into symptom specificity pertinent (see section on "Directions for future investigation into symptom specificity" below).

[35] "Social validity is described by Morrow (2005) and Ponterotto and Grieger (2007) as a criterium to enhance a study's "trustworthiness". It refers to the social value and importance of the research topic to the profession and the society at large (e.g., Ponterotto & Grieger, 2007, p.414).

targeting patients' *core relational conflicts* during therapy showed essential in fostering *interpersonal* and subsequent *symptomatic transformations*.

Consideration of the dynamics operating beneath the surface of overt symptomatic and relational manifestations elucidated that both HS patients and OS patients were – despite marked *overt differences* – *structurally interrelated* pertaining to their prevailing drive towards unison (HS patients) or separation (OS patients). This consideration is deemed highly meaningful and practicable, as the dominant medical and psychiatric gaze at overt symptomatic appearances[36] (which, importantly, often turn out to be 'shape shifters'; particularly in the case of hysterical symptoms, which have frequently been described as overtly diversified – between subjects – and liable or unstable – within individual subjects; e.g., Merskey, 1995; Verhaeghe, 2004) and related invariant application of standardized treatment manuals (that accompany particular – comorbid – DSM-/ICD-diagnoses), is regularly chaperoned by the occurrence of so-called therapy-resistant or recidivist patients (who do not seem to adequately respond to treatment). In contrast, based on the present project's findings (and as recurrently illustrated above), we argue in favor of directing an analytical ear to patients' own narrative accounts of experienced core conflicts, and accordingly shaping the therapeutic environment and *tailoring* therapist stance and interventions.

Further, in all studied patients, we pointed to the clinical practicality of *interactionally co-constructing a meaningful narrative* during therapy. Angus and Kagan (2013) previously described how patients often seek out psychotherapeutic treatment when they can no longer make sense of their life experiences. In the qualitative descriptions of studied therapy processes (see Chapters 2 – 5) we documented that, as patients progressively managed to link the start and evolutions in their symptoms to the interpersonal positions they occupied towards significant persons in their lives, they gradually started to organize and symbolize all determinants in a coherent story, thereby recounting initially enigmatic experiences in a meaningful framework. Accordingly, their *symptoms* started to make *sense* again and were increasingly less experienced as alienating or frightening. Importantly, in contrast to traditional prejudices concerning psychodynamic therapy as primarily aimed at the consciously resurfacing of hidden, unconscious meanings (i.e., the *reconstruction* of the *past*, by progressively unveiling abiding, past meanings[37]), this construction gradually developed (during, and between, therapy sessions) in the *present*[38].

Yet, *beyond* this increased level of meaning and self-understanding, '*working-through'* (e.g., Blatt, 1974, 2008; Verhaeghe, 2004) patients' core conflicts – e.g., by targeting patients' narrative accounts of significant relational interactions as experienced outside of therapy; by addressing their

[36] Often speedily measured by means of e.g., predefined self-report instruments, structured diagnostic interview questions or clinical observation of overt behavior.
[37] This theme has particularly been addressed in HS case 3 (see Chapter 4) in the context of common prejudices against reconstructing past events in cases of Dissociative Identity Disorder.
[38] This notion is echoed in the following quotation of Wittgenstein: "Freud's idea: in madness, the lock is not destroyed, only altered; the old key can no longer unlock it, but it could be opened up by a differently constructed key" (diary remark from 1938).

concrete, within-session manifestations in the therapeutic alliance; and by the gradual gaining of new, unfamiliar relational exchanges with the therapist – was observed to be a *vital vehicle for therapeutic progress* and clinical change (see also Blatt, 2008; Fink, 2014; Verhaeghe, 2004)[39].

In this respect, we motivated how explicit recognition of *interpersonal ambivalence* between dependent and autonomous issues in patients with obsessional symptoms, constitutes an inherent part of the advanced *structural* conceptualization of symptom specificity (i.e., interpersonal ambivalence was a structural part of OS patients' core conflicts). In contrast to the original conceptualization of the SSH (i.e., as tested in previous research) – which links obsessional symptoms exclusively to interpersonal exchanges directed at separation, distance and autonomy from others – we illustrated in both OS cases how identification of, and working with, weighty dependent issues in patients' interpersonal lives, substantially fostered therapeutic progress along the (predicted) self-definitional/autonomous configuration; which entailed symptom remission (specifically) and an increased general and interpersonal well-being (more broadly).

In this context, we additionally pointed to a number of significant differences between OS and HS patients pertaining to the precise *nature* and manifestation of *dependency* issues within relationships. Consideration of these distinctive experiences is deemed important for specifically tailoring therapists' stance towards patients, in an effort to foster a *constructive working alliance* that mobilizes underlying dynamics towards clinical change (see also Blatt, 1974, 2004, 2008; Verhaeghe, 2004; who pointed to the crucial role of the therapist in this respect). In line with theoretical statements (e.g., Blatt, 2008; Luborsky, 1984) and previous research observations (e.g., Blatt, Zuroff, Hawley, & Auerbach, 2010; Werbart & Levander, 2016), we observed that the distinctive nature of dependency issues in HS patients (compared to OS patients) manifested in therapy by, e.g., a higher susceptibility to *supportive* therapist interventions (compared to expressive techniques), and a distinctive stance towards therapy.

Yet, consideration of the structural drives that operate beneath manifest symptomatic and relational formations (i.e., on the level of subgroup *particularity*; based on the distinctive predominance of the unifying or separating drive) does not exclude the clinical importance of recognizing and working with significant singularities in each individual case (i.e., the level of individual *singularity*). The presented qualitative descriptions of therapy process in each of the four case studies (Chapters 2 – 5) exemplified *flexible – individually tailored – usage* of the psychodynamic treatment manual (as prescribed by Luborksy, 1984). Cross-case comparisons (in this Chapter) elucidated singular manifestations of structurally similar dynamics and core conflicts, as operating in inherently idiosyncratic contexts (to which therapeutic gains have to be transferred).

Hence, based on the present observations and in line with psychodynamic theory, we advance the clinical practicality of acknowledging the *idiosyncratic nature* of each individual subject *within*

[39] See e.g. our discussion of pronounced therapeutic progress in HS case 3, in contrast to HS case 4.

theoretically grounded and empirically sound[40] *psychodiagnostics* based on underlying *structural dynamics* that – in interaction with these idiosyncratic factors – give rise to singular symptomatic and interpersonal manifestations.

Strengths and Limitations of the Present Research Project and Directions For Future Investigation Into Symptom Specificity

Strengths

As substantiated more elaborately in the General Introduction (Chapter 1) of this doctoral dissertation, and as recurrently touched upon throughout Chapters 2 – 6, the present research project compiles a number of strengths.

Starting from inconsistent findings in previous nomothetic research on the SSH – for which various conceptual and methodological considerations were raised – the present project deliberately installed an alternative research design that provided a closer methodological match to Blatt's (1974, 2004, 2008) primary intentions to define distinctive associations between two broad types of neurotic symptoms and modes of interpersonal functioning, and to delineate their distinctive, dynamic evolutions throughout treatment processes.

In doing so, the project responded to:

- recommendations from earlier studies on symptom specificity to make use of longitudinal designs (e.g., Desmet, 2007; Pilkonis, 1988) – with additional follow-up measurements – in clinical settings (e.g., Desmet, 2007; Huprich, Rosen, & Kiss, 2013; Werbart & Forsström, 2014) with a variety of measures (e.g., Desmet, 2007);
- broader claims in psychotherapy research to direct research endeavors towards the increased use of idiographic studies (e.g., Barlow & Nock, 2009; Dattilio, Edwards & Fishman, 2010; Hill, 2012; Iwakabe & Gazzola, 2009; McLeod, 2013; Stiles, 2009; Vanheule, 2014)
- specific advises to explicitly include "thick descriptions" (Pontoretto & Grieger, 2007) of ongoing therapy process in these studies – pertaining to significant mechanisms of change and therapist interventions, sufficient contextual detail, and patients' literal wordings to illustrate researchers' interpretations (e.g., Flyvbjerg, 2006; Hanson, Creswell, Plano Clark, Petska, and Creswell, 2005; Iwakabe & Gazzola, 2009; Morrow, 2005; Yin, 1994);
- the marked absence of empirical case studies on the SSH to date (see Willemsen et al., 2015);
- recommendations to augment the contribution of individual case studies by systematic cross-case comparisons in a multiple case study (e.g., Iwakabe, 2011).

[40] However, in order to continue stimulating theory mobilization and meaningful guidance of clinical practice, ongoing scientific research into structural reduction of diversified psychopathological manifestations is quintessential. The present project's research findings therefore need to be extended by future research endeavors (see below for specific recommendations for future investigation into symptom specificity).

As such, the project attempted to meaningfully enrich existing research foundations on the SSH in a way that is both closer to complex theoretical underpinnings as to clinical dynamics (e.g., Yin, 1994), thereby contributing to theory-development through hypothesis-refinement (Stiles, 2009). The richly gathered dataset – and its in-depth (hypotheses-driven and discovery-oriented) investigation via multiple perspectives in specifically assembled research teams (to better circumvent biases pertaining to individual viewpoints and single methods) – allowed to illuminate meaningful structural dynamics in patients' (narratives about) symptomatic and interpersonal functioning, which (a) importantly nuanced and rectified sole findings that initially seemed to contradict the SSH (e.g., prevailing dependent interpersonal issues in both HS and OS patients), and which (b) resulted in a substantiated suggestion to theoretically recognize and clinically address symptom specificity in a structural sense.

Limitations

Several shortcomings of the empirical single and multiple case studies presented in this doctoral dissertation need to be addressed. First, despite the documented enriching contributions of the rich, differentiated assessment of the variables under study[41] – and despite recent claims that research is particularly enriching when it considers multiple perspectives on findings from this differentiated assessment "without necessarily seeking to resolve them into a unitary account" (Stiles, 2015) as it is deemed an "illusion to end up with a single univocal statement" in psychotherapy research (Hill, Chui and Baumann, 2013) – difficulties remain as to the interpretation of diverging findings within a study. For instance, in both cases that included salivary cortisol data (as biomarkers of patients' stress responses), increased cortisol levels were observed during follow-up period, while patients' (quantitatively and qualitatively) self-reported ill-being had remained stable and low. Sound considerations on how to coordinate these diverging findings currently remain open-ended.

Second, questions can be raised concerning the usefullness of each data source in providing this differentiated assessment, e.g., with respect to the presented health care costs. Costs proved overall low in OS case 1 and HS case 3, while unremittingly oscillating – without a clearly distinguishable trend pre/during/post treatment – in the two patients (OS case 2 and HS case 4) whose symptomatic expressions were mainly focused on bodily concerns (i.e., heart problems, and tinnitus and back aches, respectively). As the present research project was limited to four empirical case studies, extended observations on health care cost data in other studies are needed to further address its beneficial value in psychotherapy research.

Accordingly, although Stiles (2015) argued that well-documented theory-building research does not necessarily require a large number of similar cases to make observations scientifically useful, prudence is called for with regard to transferability of the project's findings, both to theory as to every-day clinical practice with other patients. Robustness of these findings is deemed worthy of further investigation.

[41] I.e., (interacting evolutions in) patients' symptomatic and interpersonal functioning prior to treatment, throughout therapy, and during follow-up.

Next, the absence of pre-treatment data (i.e., apart from health care cost data) may be regarded as a limitation, e.g., with respect to the observation that all studied patients reported significantly more dependent than autonomous interpersonal problems on the self-report questionnaire. Pre-treatment data might have shed clarifying light on the feasible consideration of a sudden breakthrough of (unprecedented) dependent needs in OS patients since the start of a meaningful romantic relationship, right before the start of therapy (while report of dependency issues could have been solidly low pre-treatment; in conceivable contrast to steadily high reported dependency issues in HS patients).

Further, data collection procedures were not entirely equal in the four case studies, e.g., cortisol data was absent in two cases, an idiosyncratically constructed item (as complementing the standardized items of applied questionnaires) was only available in OS case 1 (see Chapter 2), and length of the follow-up assessment period varied between cases. In addition, according to the naturalistic nature of the studied therapies, treatment length varied between the cases.

Additionally, we opted for audiotaped instead of videotaped materials, as the first is deemed less invasive. Consequently, however, no (potentially valuable) data were available on patients' non-verbal behaviors during therapy.

Finally, absence of (standardized) process measures of patients' experience of the treatment process throughout therapy might be considered as a shortcoming.

Directions For Future Investigation Into Symptom Specificity

The present project aimed to address several conceptual and methodological limitations intrinsic to statistical hypothesis testing research in cross-sectional group designs, in an effort to further enhance a rich understanding of symptom specificity. Accordingly, however, restrictions apply in statistical generalizability of the results to broader populations of neurotic (hysterical and obsessional) subjects. Therefore, the applicability of the proposed hypothesis-refinement (i.e., a structural conceptualization of symptom specificity that includes interpersonal ambivalence between dependent and autonomous interpersonal functioning as an inherent part of the separation process prevailing in OS patients) should be critically tested in additional (single and multiple case, and larger scale) studies of neurotic subjects.

Foremost, in light of possible methodological artifacts of applied (quantitative and qualitative) instruments that might have distorted findings (as addressed above), future examination of subjects' symptomatic and interpersonal functioning should additionally make use of alternative (possibly more advanced) assessment tools[42], in order to enable critical comparison between (con- and diverging) findings from different methods.

[42] It would especially be profitable to contrast our observation of an overall higher dependent sub-profile in all patients (as assessed by means of IIP-32) to findings from future studies that assess interpersonal functioning by means of other outcome measures. Choice for usage of IIP-32 in the current project was based on substantiated conclusions from previous research (Desmet, 2007) that DEQ (Depressive Experiences Questionnaire; Blatt, D'Aflitti, & Quinlan, 1976) – although co-constructed by Blatt, and an interesting questionnaire to measure the global anaclitic/dependent and

Next, based on the observed surplus value and in light of Blatt's primary intentions (see above), we recommend future studies to include longitudinal investigations of dynamic symptom-interpersonal associations over time. (a) First in individual (clinical) contexts (i.e., series of single and multiple case studies), using quantitative intra-subject correlations, and qualitative examinations of change processes (e.g., CQR-c, Grounded Theory methodology,…); (b) Subsequently, it would be valuable to aggregate these findings over groups of subjects to make statements about subgroup-level patterns. In this way, findings can be contrasted as to whether (dis)similar patterns can be found in underlying processes responsible for interpersonal and symptomatic alterations that led up to the discussed treatment outcome (see also Iwakabe & Gazzola, 2009). Additionally, quantitative-qualitative examinations of change processes occurring in psychotherapies from alternative treatment schools, grant the possibility of yielding (distinctive) observations that fail to correspond to the classical SSH, thereby stimulating further theory improvements (e.g., Stiles, 2015).

Finally, we specifically recommend to conduct a large number of (single and multiple) case studies within a global randomized design, in which patients with prevailing anaclitic/dependent or self-critical/introjective/autonomous configurations are randomly assigned to different treatment conditions (i.e., from alternative treatment schools), in order to examine (possibly distinctive) interactions between symptomatic and interpersonal evolutions, on the one hand, and specific therapeutic factors, on the other. In this respect, we pointed in the General Introduction to a currently operational large-scale Randomized Controlled Trial (RCT) study conducted at the Department of Psychoanalysis and Clinical Consulting. This RCT study is listed on the online 'Open Science Framework' as the 'Ghent Psychotherapy Study' (GPS), entitled 'Differential Efficacy of Supportive-Expressive and Cognitive-Behavioral Interventions in Dependent and Self-critical Depressive Patients: A Randomized Trial'[43].

self-critical/introjective/autonomous personality traits – is deemed unsuitable to investigate associations with symptom measures. Therefore, Desmet (2007) specifically recommended to use IIP-64 (the longer version of the currently used IIP-32) or PSI-II (Personal Style Inventory-II; Robins, Ladd, Welkowitz, Blaney, Diaz, & Kutcher, 1994), as these questionnaires measure (in contrast to DEQ) merely interpersonal characteristics and show little content overlap with symptom measures. Amongst other alternative instruments, use of IIP-64 and PSI-II in future studies would thus be valuable.

[43] For details, see https://osf.io/mf2d7/

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“Niets is meer wonderbare materie, is meer rijk, meer vol van geheimen en alle inspanningen van het menselijk intellect waardig dan het psychisch leven” (Sigmund Freud, 26-03-1929).

NEDERLANDSTALIGE SAMENVATTING

Interacties tussen neurotische symptomen en interpersoonlijke dynamieken doorheen psychodynamische psychotherapie: vier empirische gevalsstudies

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Het huidige doctoraatsproject vertrok vanuit psychodynamische noties rond de inherent structurele inbedding van neurotische symptomen in het ruimere interpersoonlijk functioneren van subjecten (e.g., Blatt, 1974, 2004, 2008; Luborsky, 1984; Vanheule, 2014; Verhaeghe, 2004), en stelde daarbij specifiek scherp op het bestuderen van dynamische interacties tussen evoluties in symptomatisch en interpersoonlijk functioneren (met specifieke aandacht voor intra- en extra-therapeutische beïnvloedende factoren op dit proces) doorheen het naturalistisch[44] verloop van Ondersteunende-Expressieve Psychodynamische Therapie[45] (i.e., Supportive-Expressive Therapy, SET; Luborsky, 1984).

In de ***Algemene Introductie (Hoofdstuk 1)*** werd het theoretisch en empirisch achtergrondkader van het onderzoeksproject verhelderd. Algemeen werd vertrokken vanuit de probleemstelling dat de internationaal meest gebruikte diagnostische systemen[46] – door hun descriptieve focus op de uiteenlopende manifestaties van neurotische symptomen – algemeen gepaard gaan met een grootse hoeveelheid geïsoleerde diagnostische categorieën die klinisch weinig werkzaam blijken (e.g., Vanheule, 2014). In een poging deze fenomenologische diversiteit op een klinisch zinvolle manier te reduceren – i.e., door het identificeren en verhelderen van onderliggende dynamieken die de (ogenschijnlijk verscheidene) symptoomformaties structureel met elkaar verbinden – formuleerde Blatt (1974, 2004, 2008) een psychodynamisch georiënteerde theorie waarin verondersteld wordt dat subjectief functioneren hoofdzakelijk gedreven wordt vanuit twee dimensionele configuraties. De anaclitische configuratie is hierbij voornamelijk gericht op het installeren van een mature interpersoonlijke verbondenheid met anderen, terwijl de introjectieve configuratie het uitbouwen van een stabiele, gedifferentieerde zelf-definitie voortstuwt. In normaal (i.e., niet-pathologisch) functioneren zouden beide dimensies in onderlinge synergie werkzaam zijn, terwijl pathologisch (i.e., symptomatisch) functioneren gekenmerkt wordt door een buitensporige focus op één van beide configuraties, ten koste van een mature ontwikkeling op de andere configuratie. Overdreven nadruk op het installeren en behouden van relationele verbondenheid overweegt in

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[44] Met “naturalistisch” verwijzen we in deze context naar het natuurlijk verloop van het therapieproces zoals het zich gradueel ontvouwde tussen patiënt en therapeut, zonder ingrijpen van het onderzoeksteam.

[45] Vrije vertaling van “Supportive-Expressive Psychodynamic Therapy” (SET; Luborsky, 1984).

[46] Dit zijn de “Diagnostic and Statistical Manuals” (DSM; American Psychiatric Association) en de “International Classification of Diseases and Related Health Problems” (ICD; World Health Organization).

zogenaamd afhankelijke pathologie; terwijl preoccupatie met zelf-definitie de bovenhand heeft in zogenaamd autonome pathologie. De grote verscheidenheid aan overte symptomatische expressies binnen het veld van de neurotische[47] psychopathologie zou aldus structureel te reduceren zijn tot twee 'types' pathologie. Elk van beide types pathologie wordt verder verondersteld samen te gaan met particuliere types van neurotische symptomen en met karakteristieke manieren van interpersoonlijk functioneren (gekenmerkt door typische verlangens, noden, gevoeligheden en reacties in relationele uitwisselingen); wat geformaliseerd werd in de Symptoom Specificiteitshypothese (SSH; Blatt, 1974, pp.155-157). Concreet stelt de SSH dat het typisch afhankelijk interpersoonlijk profiel specifiek geassocieerd is met typisch hysterische symptomen; terwijl het prototypisch autonoom interpersoonlijk profiel distinctief gerelateerd zou zijn aan typisch obsessionele symptomen[48].

We illustreerden dat de SSH in voorgaand onderzoek inconsistente resultaten opleverde, waarbij sommige studies evidentie vonden voor symptoomspecificiteit, andere niet, en nog andere slechts voor delen ervan (cf. ook Desmet, 2007). We beargumenteerden hoe deze inconsistentie toegeschreven zou kunnen worden aan verscheidene conceptuele en/of methodologische consideraties, die principieel verband houden met de cross-sectionele groepsdesigns van genoemde studies (i.e., symptomatisch en interpersoonlijk functioneren werd uitsluitend op één tijdsmoment, op groepsniveau, en via zelf-rapportage vragenlijsten in kaart gebracht). We lichtten verder toe hoe Blatt's theorie echter principieel doelde op het definiëren van dynamisch ontvouwende interacties tussen symptomen en interpersoonlijke karakteristieken over de tijd heen (meer algemeen) en gedurende het verloop van een therapieproces (in het bijzonder). In respons substantieerden we op basis van verschillende argumenten de dringende nood om de SSH te onderzoeken in empirische gevalstudies van longitudinale psychotherapie processen, gebruik makend van extensieve datasets, die verzameld werden via verscheidene (kwantitatieve en kwalitatieve) methodes vanuit verschillende (patiënt-, therapeut-, onderzoekers-) perspectieven; bij voorkeur bestudeerd via triangulatie binnen een specifiek samengesteld team van onderzoekers. We documenteerden verder hoe het huidige doctoraatsproject een antwoord bood op deze nood – aldus een hogere methodologische "match" met Blatt's primaire intenties doelde op te leveren – en op die manier poogde de huidige onderzoeksfundamenten van de SSH op een theoretisch en klinisch zinvolle manier te verrijken.

Meer specifiek lichtten we uitvoeriger toe hoe de SSH in het huidige doctoraatsproject achtereenvolgend getest werd in ***vier individuele empirische gevalstudies (Hoofdstukken 2 – 5)***

[47] In ons gebruik van de termen "neurose/neurotisch", "hysterisch" en "obsessioneel", verwijzen we specifiek naar hedendaagse *psychodynamische diagnostiek* vanuit *Freudiaans-Lacaniaans kader*, zoals geconceptualiseerd door Verhaeghe (2004) – ook wel structurele of functiegerichte diagnostiek genoemd (e.g., Vanheule, 2014) – waarin een diagnostisch onderscheid wordt gemaakt tussen neurotische, psychotische en perverte subjectieve structuren. Het huidige doctoraatsproefschrift focust op symptomatisch en interpersoonlijk functioneren binnen de *neurotische structuur*, waarin verder een onderscheid wordt gemaakt tussen een eerder *hysterische* en een eerder *obsessionele* psychopathologische positie.

[48] Voor genuanceerde documentatie van Blatt's (1974, 2004, 2008) ruimere theorie en de SSH in het bijzonder, verwijzen we naar de Algemene Inleiding (General Introduction) van het doctoraatsproefschrift.

van neurotische patiënten behandeld door dezelfde therapeut in een naturalistische klinische praktijk op basis van Ondersteunende-Expressieve Therapie (Luborsky, 1984); waarvan de belangrijkste bevindingen vervolgens systematisch vergeleken en kritisch geïntegreerd werden in de vorm van een ***meervoudige empirische gevalstudie*** (Yin, 2014; uiteengezet in de ***Algemene Discussie, Hoofdstuk 6)***.

Ondersteunende-Expressieve Therapie (Luborsky, 1984) wordt algemeen erkend de meest toegepaste en representatieve psychodynamische technieken te bevatten (wat het doctoraatsproject belangwekkend maakt voor een groot aantal psychodynamische therapeuten), en is bovendien gebaseerd op een theorie (Luborsky, 1962) die in beduidende overeenstemming blijkt met de theoretische uitspraken van Blatt (1974, 2004, 2008) die het uitgangspunt vormden voor het huidige onderzoeksproject (wat deze therapieën bijgevolg geschikt maakt voor studie van de SSH).

We staafden verder dat voor deze empirische gevalstudies vier patiënten geselecteerd werden uit een ruimere database[49], i.e., twee patiënten met prototypisch obsessionele symptomen (Hoofdstukken 2 – 3) en twee patiënten met prototypisch hysterische symptomen (Hoofdstukken 4 – 5).

In elke empirische gevalstudie waren de overkoepelende onderzoeksdoelen tweeledig:

1. Het testen van concrete operationalisaties van de SSH (gedetailleerd gepresenteerd in Tabellen 3 – 4 van de Algemene Introductie, en hieronder algemener gevisualiseerd in Tabel 1; i.e., in overeenstemming met voorgaand onderzoek naar symptoom specificiteit),

   Teneinde specifiek af te lijnen wat een test constitueert voor de SSH.

   I.e., het *hypothese-gedreven deel* van elke studie.

2. Bijkomend (voorbij de scope van voorgaand onderzoek) het diepgaand bestuderen van dynamisch ontvouwende associaties tussen het symptomatisch en interpersoonlijk functioneren van de patiënt doorheen het therapeutisch proces, daarbij specifiek aandacht bestedend aan therapeutische interventies en extra-therapeutische gebeurtenissen/ factoren die dit ontwikkelend proces beïnvloedden,

   Teneinde identificatie mogelijk te maken van betekenisvolle, onverwachte bevindingen en factoren die niet expliciet deel uitmaakten van de SSH als uitgangshypothese, en die specifieke gebieden zouden kunnen aanwijzen waarin de SSH mogelijks verfijnd dient te worden, i.e., op basis van voorgestelde complexiteiten (extensies en/of modificaties).

   I.e., het *exploratieve* (Hill, 1990) of *ontdekkings-gedreven* (Mahrer, 1988) *deel* van elke studie.

We becommentarieerden vervolgens hoe een verrijkende bijdrage van systematisch uitgevoerde, grondig gesubstantieerde gevalstudies ligt in de “transferabiliteit” (overdraagbaarheid; Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005) van onderbouwde observaties naar theorie-

[49] Geconstrueerd aan de Vakgroep Psychoanalyse en Raadplegingspsychologie van de Universiteit Gent; specifieke details rond deze database en casus selectie worden voorzien in de Algemene Inleiding.

ontwikkeling (Stiles, 2009, 2015), en in de klinische toepasbaarheid van deze bevindingen (e.g., Flyvbjerg, 2006; Iwakabe, 2011; McLeod, 2013). Daarbovenop adresseerden we aanbevelingen uit voorgaand onderzoek (e.g., Iwakabe, 2011; Iwakabe & Gazzola, 2009) om de bijdrage van individuele gevalstudies kracht bij te zetten door zorgvuldige, systematische vergelijking van hun bevindingen in een meervoudige gevalstudie (Yin, 1994; gepresenteerd in de Algemene Discussie van het huidige proefschrift). Hierin worden de kwantitatieve en kwalitatieve bevindingen van de hypothese- en ontdekkings-gedreven delen van de vier gevalstudies systematisch naast elkaar geplaatst en – zowel binnen, tussen, als over de twee paren van gelijkaardig gediagnosticeerde patiënten heen – vergeleken, in een poging overeenkomsten, terugkerende observaties en gemeenschappelijke thema's te identificeren en te articuleren, alsook significante verschillen, en dit zowel met betrekking tot manifeste constructen als onderliggende dynamieken.

Tabel 1
Algemene Onderzoeksvragen met betrekking tot Symptomatische-Interpersoonlijke Associaties Patiënten

Obsessionele symptomen (Casussen 1 – 2)	Hysterische symptomen (Casussen 2 – 3)
Voor aanvang therapie (gedurende intake fase) verwachten we dat symptomen geassocieerd zullen zijn met:	
Autonome interpersoonlijke stijl uitgedrukt in buitensporige nadruk op: ▪ definitie van het zelf, als onderscheiden van anderen ▪ separatie van anderen	Afhankelijke interpersoonlijke stijl uitgedrukt in buitensporige nadruk op: ▪ interpersoonlijke verbondenheid ▪ nabijheid, intimiteit met anderen
Doorheen het therapeutisch proces, verwachten we:	
▪ SET zal buitensporig streven naar autonomie en onafhankelijkheid van anderen – en gerelateerde verwaarlozing van het installeren van interpersoonlijke verbondenheid – reduceren ▪ Obsessionele symptomen zullen vervolgens afnemen	▪ SET zal buitensporig streven naar interpersoonlijke verbondenheid – en gerelateerde verwaarlozing van het ontwikkelen van een stabiele, gedifferentieerde zelf-definitie – reduceren ▪ Hysterische symptomen zullen vervolgens afnemen

Noot. SET = Supportive-Expressive Therapy (Luborsky, 1984; hierboven vrij vertaald als Ondersteunende-Expressieve Therapie).

Om de kans te verhogen de bedoelde complexiteiten te vatten, en verschillende aspecten van (het brede spectrum van mogelijke veranderingen in) de variabelen onder studie (e.g., Hill, Chui, & Baumann, 2013) te belichten, bouwt iedere empirische gevalstudie op een rijke dataset (gedetailleerd gepresenteerd in Tabellen 1 en 2 van de Algemene Introductie, Hoofdstuk 1; en hieronder algemener gevisualiseerd in Tabel 2), verzameld via verschillende bronnen van kwantitatief en kwalitatief onderzoeksmateriaal, verkregen vanuit verschillende perspectieven, en longitudinaal gecollecteerd op regelmatige tijdsintervallen (voorafgaand aan de therapie, doorheen de therapie en op verschillende follow-up meetmomenten).

Tabel 2
Kwalitatief en kwantitatief materiaal van symptomatisch en interpersoonlijk functioneren patiënten

Kwalitatief materiaal	
Audio-opnames + verbatim transcripties van ▪ Diagnostisch interview ▪ Therapie sessies ▪ Semi-gestructureerd veranderingsinterview	Sessieverslagen therapeut

Kwantitatief materiaal		
	Symptomatisch functioneren	*Interpersoonlijk functioneren*
Patiënt	Zelf-rapportage vragenlijsten	Zelf-rapportage vragenlijst
Onderzoeker	Schaal voor de algemene beoordeling van het functioneren	Schaal voor de algemene beoordeling van het functioneren
Onpartijdig	Salivaire cortisol concentratie Kosten gezondheidszorg	

Noot. Diagnostisch interview = Structured Clinical Interview voor DSM-IV-TR diagnostiek (APA, 2000); Therapie = Supportive-Expressive Therapy (Luborsky, 1984); Semi-gestructureerd veranderingsinterview = Semi-structured Change Interview (SCI; Elliott, 1999; Elliott, Slatick, & Urman, 2001); Schaal voor de algemene beoordeling van het functioneren = Nederlandstalige versie van Global Assessment of Functioning (GAF; DSM-IV-TR; APA, 2000); gezondheidszorgkosten werden opgevraagd door een onderzoeker bij de ziektekostenverzekeringsfondsen (mutualiteiten) van de respectieve patiënten.

Om conformiteit te bieden tussen de SET therapieën onder studie, en de empirische analyses op data uit deze therapieën, wordt in elke gevalstudie Core Conflictual Relationship Theme (CCRT; Luborksy & Crits-Christoph, 1998) methodologie toegepast om (patiënt-narratieven over) het interpersoonlijk functioneren te analyseren. CCRT wordt bovendien omschreven als een systematische, klinisch relevante en veel gebruikte methode in hedendaags psychotherapieonderzoek.

Als overkoepelende data-analytische benadering wordt gekozen voor Consensual Qualitative Research for Case Studies (CQR-c; Jackson, Chui and Hill, 2011), die specifiek ontworpen is om klinisch complex materiaal op een rijke en genuanceerde manier in kaart te brengen. Gedurende dit data-analytisch proces, wordt triangulatie (e.g., Hill, 2012; Yin, 1994) expliciet geïnstalleerd tussen verschillende databronnen, tussen rivaliserende perspectieven, en via kritische intercommunie tussen een leidende operationele set van theoretische uitspraken en een voortdurende terugkeer naar het ruwe materiaal.

We beëindigden de Algemene Introductie met het expliciet beargumenteren van de methodologische en data-analytische stappen die we doorheen het onderzoeksproces doelbewust ingebouwd hebben om individuele bias en vertekeningen (door gebruik van individuele methodes en/of perspectieven) terug te dringen en gingen daarbij specifiek in op concepten als sociale validiteit (e.g., Morrow, 2005; Ponterotto & Grieger, 2007), interne en construct validiteit (Yin, 1994), betrouwbaarheid (e.g., Elliott, Fischer, & Rennie, 1999; Hill, 2012), reflexiviteit (Rennie, 2004), credibiliteit (Morrow, 2005), analytische generaliseerbaarheid (Yin, 1994) en overdraagbaarheid van de bevindingen (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005).

Als zodanig startte het onderzoeksproject in ***Hoofdstuk 2*** met een ***eerste empirische gevalstudie*** van een patiënt met een prototypisch ***obsessionele symptomatologie***. We illustreerden hoe betekenisvolle associaties geobserveerd werden (a) tussen symptomatisch en interpersoonlijk functioneren, en (b) tussen therapeutische interventies die focusten op relationele kernconflicten en interpersoonlijke en symptomatische transformaties. Echter, in plaats van in de voorspelde dominantie van separerend interpersoonlijk gedrag, bleken obsessionele symptomen genesteld te zijn in opmerkelijke ambivalente alternaties tussen autonomie en afhankelijkheid. Meer specifiek, recente separerende pogingen om te verdedigen tegen (lang bestaande) afhankelijke problemen determineerden de obsessionele symptomen van de patiënt. Interpersoonlijke ambivalentie uitte zich zowel binnen relationele uitwisselingen als tussen betekenisvolle relaties, wat een hogere complexiteit suggereerde dan initieel verondersteld door de klassieke SSH. De geobserveerde complexiteit bleek bovendien in overeenstemming met de ruimere theoretische grondvestingen van de SSH. Zowel klassieke (e.g., Freud, Lacan) als meer hedendaagse (e.g., Blatt, Luborsky) psychodynamische theorieën documenteren immers dat overheersende separerende processen in obsessionele subjecten nauw samengaan met interpersoonlijke ambivalentie (verwijzend naar de inherent hysterische grondslag van elke obsessionele neurose; e.g., Verhaeghe, 2004).

Vervolgens werd de klinische complexiteit van associaties tussen obsessionele symptomen en specifieke interpersoonlijke dynamieken verder onderzocht in de ***tweede empirische gevalstudie*** in ***Hoofdstuk 3***. In het bijzonder werden concrete operationalisaties op basis van de klassieke SSH gecontrasteerd aan alternatieve hypotheses op basis van de geobserveerde complexiteiten in hoofdstuk 2. Ook hier documenteerden we nauwe associaties tussen symptomatische en interpersoonlijke dynamieken, inwerkende therapeutische interventies en extra-therapeutische invloeden. Eveneens gelijkaardig aan de eerste gevalstudie, werden sterke interpersoonlijke ambivalenties geobserveerd in deze patiënt. Er konden echter een aantal significante verschillen opgemerkt worden tussen gevalstudie 1 en 2 met betrekking tot de aard en concrete expressies van deze ambivalentie binnen betekenisvolle relaties; die verder besproken werden in de meervoudige gevalstudie in de *Algemene Discussie* van het doctoraatsproefschrift.

Hoofdstuk 4 vatte daaropvolgend aan met een ***eerste empirische gevalstudie*** van een patiënt met prototypisch ***hysterische symptomatologie***. In contrast met de gevalstudies rond obsessionele symptomen – die allebei een hogere complexiteit onthulden dan voorspeld door de SSH en bijgevolg resulteerden in suggesties voor hypothese-verfijning – documenteerde deze gevalstudie confirmerende evidentie voor alle SSH predicties.

Bijgevolg startte de ***tweede empirische gevalstudie*** rond hysterische symptomen in ***Hoofdstuk 5*** opnieuw vanuit de klassieke SSH voorspellingen, om vervolgens verder te gaan op het diepgaand bestuderen van dynamische interacties tussen symptomatisch en interpersoonlijk functioneren doorheen de therapie. Hier werden echter een aantal elementen geobserveerd die in eerste instantie moeilijk verenigbaar bleken met de SSH, maar op basis van grondige kwalitatieve

analyses van het narratief materiaal in lijn bleken te liggen met typisch hysterische/afhankelijke structurele dynamieken (die symptoom- en interpersoonlijke formaties stuwden), en zo confirmerende evidentie aanbrachten voor de eerder besproken psychodynamische grondslagen van de SSH.

In het besluitende hoofdstuk *(**Algemene Discussie en Conclusies**)* werden de geobserveerde bevindingen van de vier empirische gevalstudies vervolgens grondig en systematisch vergeleken op basis van "cross-case comparison" aanbevelingen (e.g., Iwakabe, 2011; Iwakabe & Gazzola, 2009), kritisch geïntegreerd en uitvoerig gesubstantieerd in het licht van eerder empirisch onderzoek, en klassieke en hedendaagse theorievorming.

We illustreerden onder andere hoe evidentie voor de SSH het grootst bleek in de gevalstudies rond hysterische symptomen; hoe initieel ogende afwijkingen van de SSH in de tweede hysterische patiënt – op basis van consideratie van structurele dynamieken –symptoom specificiteit niet fundamenteel tegenspraken; hoe identificatie en therapeutisch werk met betrekking tot deze structurele dynamieken verschilde tussen de twee hysterische patiënten en gepaard gingen met markante verschillen in therapeutische vooruitgang/obstructie en klinische veranderingen; hoe – in tegenstelling tot SSH predicties – (interpersoonlijke) afhankelijkheid een pertinente rol speelde in zowel hysterische als obsessionele patiënten en hoe uitvoerige kwalitatieve analyses van het narratief onderzoeksmateriaal – in uitbreiding op kwantitatieve data – licht wierp op het significant verschillende statuut van deze afhankelijkheid in obsessionele patiënten, vergeleken met hysterische. We substantieerden dat, ondanks idiosyncratische verschillen in concrete symptomatische en interpersoonlijke manifestaties tussen de vier bestudeerde gevallen, gelijkaardige structurele dynamieken geobserveerd werden tussen de obsessionele patiënten onderling (i.e., met betrekking tot de overheersende separatie drift), en tussen de hysterische subjecten onderling (i.e., met betrekking tot dominante inclinaties gericht op eenmaking). Meer specifiek schoven we naar voor dat, in lijn met onder andere psychodynamische theorievorming vanuit Freudiaans-Lacaniaanse oriëntatie (Verhaeghe, 2004):

- Obsessionele symptomen (als reactieformaties) typisch samen gingen met overwegende interpersoonlijke neigingen naar isolatie en autonomie – echter steeds vergezeld door de karakteristieke ambivalentie – via dominantie van het structureel onderliggend separatie proces;
- Hysterische symptomen (als compromisformaties) typisch gepaard gingen met overheersende interpersoonlijke tendensen naar fusie en liefde, via dominantie van het structureel onderliggend eenmakingsproces.

We lichtten verder toe hoe deze structurele conceptualisatie essentieel getraceerd kan worden in de ruimere psychodynamische theorie waarop de SSH gebaseerd is, en op welke manier deze verloren is gegaan door empirische operationalisatie voor nomothetisch onderzoek.

Aldus schoven we, op basis van de besproken bevindingen uit het huidige onderzoeksproject, een *structurele conceptualisatie van symptoom specificiteit* – (a) gericht op de structurele dynamieken die symptoomformaties en interpersoonlijk functioneren drijven *en* (b) met inbegrip van interpersoonlijke

ambivalentie als inherent horend bij het overheersende separatie proces in obsessionele dynamieken – als theoretisch zinvoller en klinisch toepasbaarder dan de huidige conceptualisatie van de SSH (veelal gericht op overte manifeste constructen).

We eindigden de *Algemene Discussie* met consideratie van enkele sterktes en limitaties van het huidige onderzoeksproject en schoven op basis daarvan waardevolle richtingen naar voor toekomstig onderzoek inzake symptoom specificiteit.

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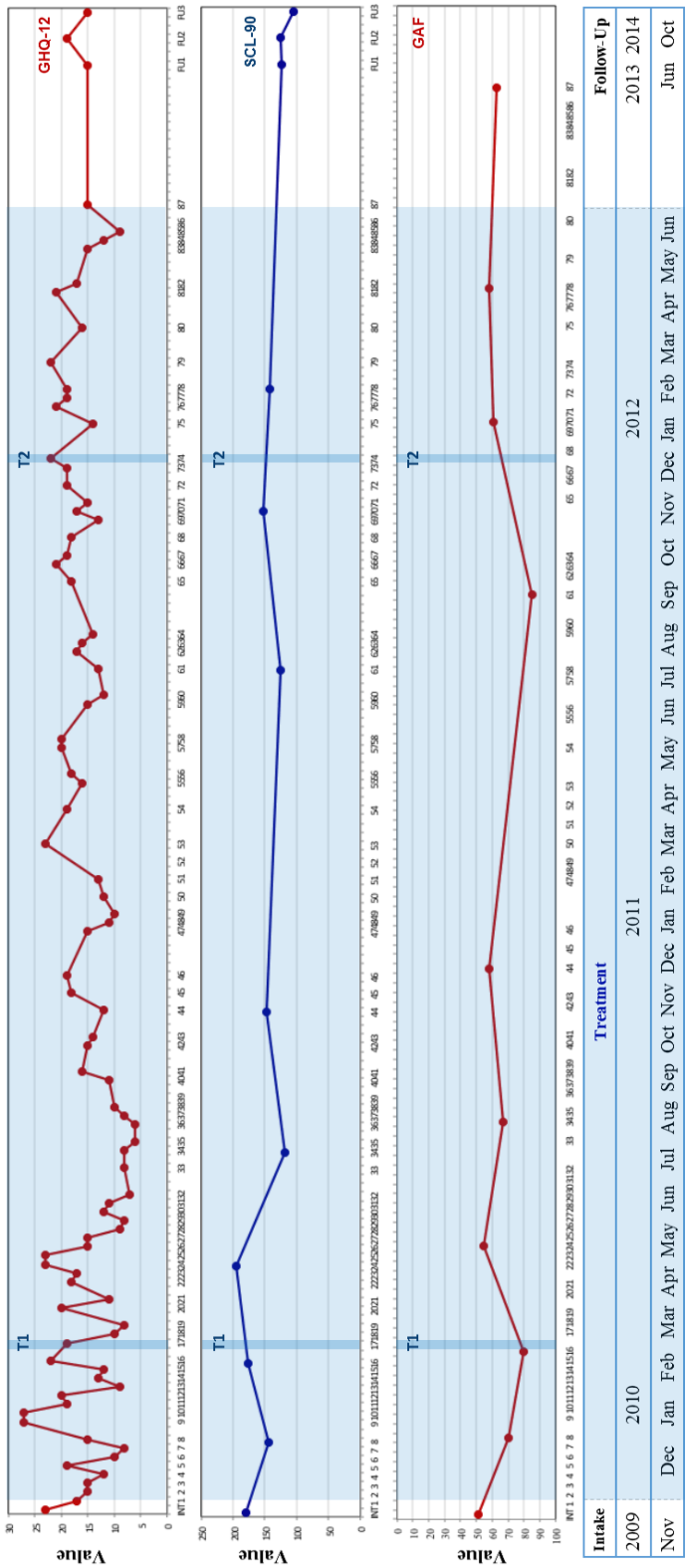
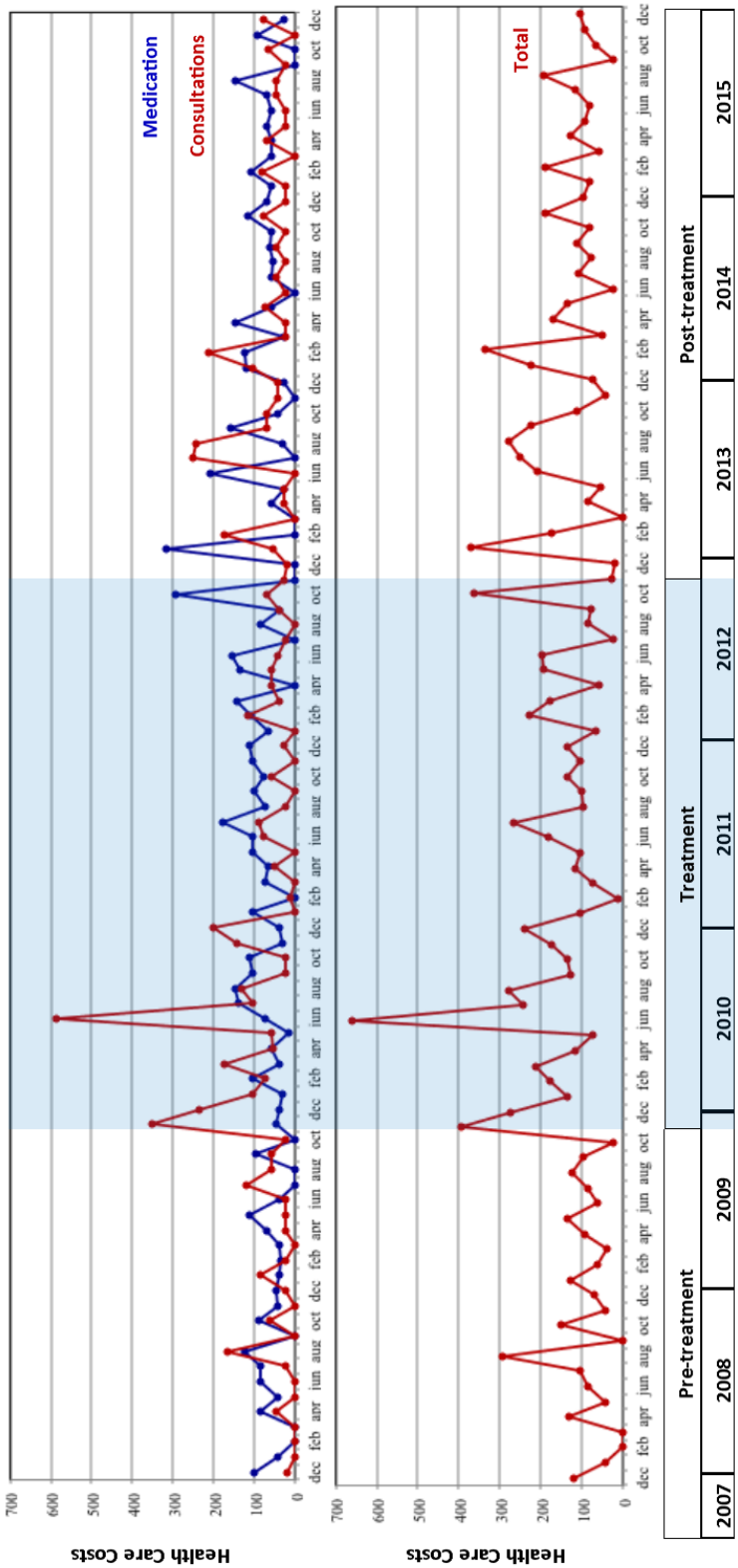
APPENDIX 1

Chapter 5, Figure 1 (vertically presented). Evolutions in patient- and researcher-rated well-being from intake to follow-up. GHQ-12 = General Health Questionnaire-12; SCL-90 = Symptom Checklist-90-Revised; GAF = Global Assessment of Functioning; T1 = Tipping point 1; T2 = Tipping Point 2.



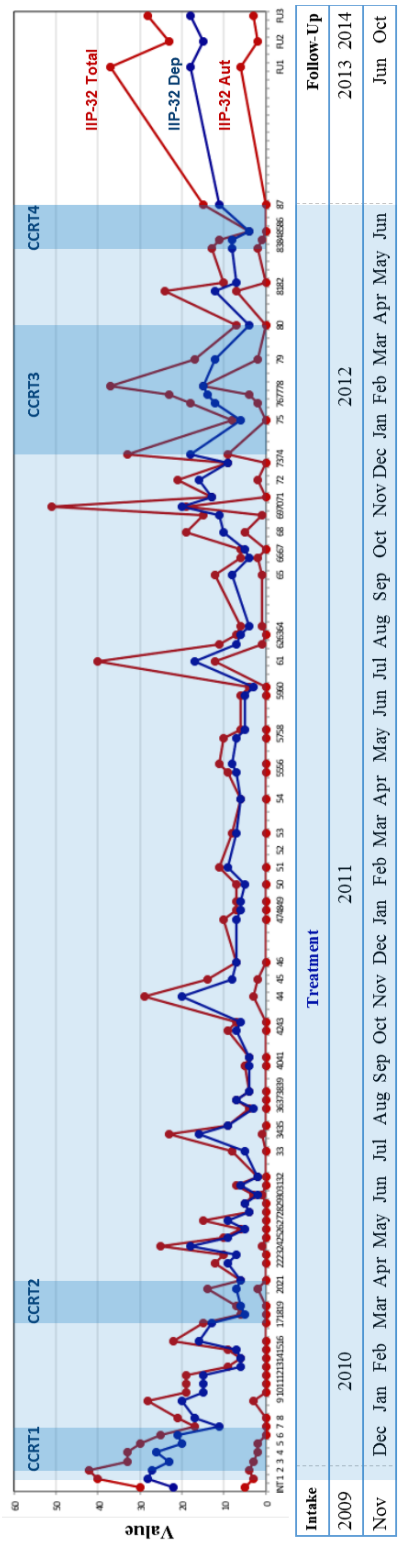
APPENDIX 2

Chapter 5, Figure 2 (vertically presented). Evolutions in patient's health care costs (euro) from two years before onset of treatment until follow-up.



APPENDIX 3

Chapter 5, Figure 3 (vertically presented). Evolutions in patient-reported interpersonal problems from intake to follow-up. IIP-32 Total = Inventory of Interpersonal Problems-32 total scores; IIP-32 Dep = Inventory of Interpersonal Problems-32 subscores dependency; IIP-32 Aut = Inventory of Interpersonal Problems-32 subscores autonomy; CCRT1 = Conflictual Relationship Theme codings of first three sessions; CCRT2 = Conflictual Relationship Theme codings of Tipping point 1 sessions; CCRT3 = Conflictual Relationship Theme codings of Tipping point 2 sessions; CCRT4 = Conflictual Relationship Theme codings of last four sessions.



APPENDIX 4

DATA STORAGE FACT SHEET

Name/identifier study: PhD Dissertation Shana Cornelis “Interactions between neurotic symptoms and interpersonal dynamics throughout psychodynamic psychotherapy: Four empirical case studies”
Author: Shana Cornelis
Date: 17/06/2016

1. Contact details
==========

1a. Main researcher

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If a response is not received when using the above contact details, please send an email to data.pp@ugent.be or contact Data Management, Faculty of Psychology and Educational Sciences, Henri Dunantlaan 2, 9000 Ghent, Belgium.

2. Information about the datasets to which this sheet applies
==========

* Reference of the publication in which the datasets are reported:

Doctoral dissertation: Cornelis, S. (2016). Interactions between neurotic symptoms and interpersonal dynamics throughout psychodynamic psychotherapy: Four empirical case studies

Chapter 2 of the doctoral dissertation has been published as an online article in Psychoanalytic Psychology (see biblio.ugent.be) and is currently in press. Reference:
Cornelis, S., Desmet, M., Meganck, R., Cauwe, J., Inslegers, R., Willemsen, J., Van Nieuwenhove, K., Vanheule, S., Feyaerts, J., & Vandenbergen, J. (2016). Interactions between obsessional symptoms

and interpersonal dynamics: An empirical single case study. *Psychoanalytic Psychology*. Advance online publication. doi: http://dx.doi.org/10.1037/pap0000078

* Which datasets in that publication does this sheet apply to?: All data.

3. Information about the files that have been stored

==========

3a. Raw data

---

* Have the raw data been stored by the main researcher? [X] YES / [ ] NO

If NO, please justify:

* On which platform are the raw data stored?

- [X] researcher PC
- [X] research group file server
- [ ] other (specify): ...

* Who has direct access to the raw data (i.e., without intervention of another person)?

- [X] main researcher
- [X] responsible ZAP
- [X] all members of the research group
- [ ] all members of UGent
- [ ] other (specify): ...

3b. Other files

---

* Which other files have been stored?

- [X] file(s) describing the transition from raw data to reported results. Specify: SPSS syntax files that were used for the analyses of the quantitative raw data; .doc files containing specific coding schemes of the Core Conflictual Relationship Theme method (CCRT; Luborsky & Crits-Christoph, 1998); .doc files with descriptions of the quantitative and qualitative data-analytic steps.

- [X] file(s) containing processed data. Specify: .doc files containing the verbatim transcripts of audio-recorded therapy sessions; Excel files containing processed (i.e., cleaned, and categorized per theme and per month) health care costs; Excel files containing concise overviews of salivary hormone values.

- [X] file(s) containing analyses. Specify: Excel files containing output of the statistical analyses via above-mentioned SPSS syntaxes, and corresponding graphs; .doc files containing CCRT-codings; .doc files with output of the qualitative analysis process.

- [X] files(s) containing information about informed consent

- [X] a file specifying legal and ethical provisions

- [X] file(s) that describe the content of the stored files and how this content should be interpreted. Specify: .doc files that describe the available data for each patient, including number of audio-recordings, of transcriptions, of therapist session reports and of salivary hormone measurements; a .doc file with a description of salivary hormone collection and subsequent analyses, and correspondence details of lab responsible for salivary hormone analyses; a .doc file with the exact dates of each therapy session, the dates on which health care costs and saliva were retrieved; a .doc file with the exact procedure of data collection; a .doc file with information on where each raw data source is stored on the research group file server.

- [ ] other files. Specify: ...

* On which platform are these other files stored?
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- [ ] other: ...

* Who has direct access to these other files (i.e., without intervention of another person)?
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